State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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MATERNAL AND CHILD HEALTH BLOCK GRANT

ANNUAL PLAN

Fiscal Year 1999

and

APPLICATION

Fiscal Year 2001

Oregon Department of Human Services
Oregon Health Division
Center for Child and Family Health
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OREGON TITLE V
MATERNAL AND CHILD HEALTH BLOCK GRANT
1999 Report and 2001 Application

1.3 Table of Contents

1.4 Overview of the State

Mission and Goals. The Title V Agency for Oregon is the Center for Child and Family Health, Oregon Health Division, Department of Human Services, located in Portland, Oregon. The Child Development and Rehabilitation Center (CDRC) administers the Oregon Services to Children with Special Health Care Needs (OSCSHN) Title V Program at the Oregon Health Sciences University (OHSU). The agencies work together under an interagency agreement to achieve the goals set forth by the Title V legislation.

Center for Child and Family Health:

The mission of the Center for Child and Family Health, Oregon Health Division, is to:

Provide leadership for improving health outcomes for women, children, and families through:

- collecting and sharing data to assess the health of women, children and families;
- developing and implementing public health policy based on these data;
- assuring the availability, quality and accessibility of health services and health promotion; and,
- providing technical assistance, consultation, and and resource to local health departments and other community partners

CCFH reorganized in 1999 into seven sections that work closely together on maternal and child health issues. The sections represent programs and services that provide infrastructure, consultation, and technical assistance to local and state organizations working to improve health of the MCH population. The sections are: Women's and Reproductive Health, Perinatal and Child Health, Adolescent Health (new), Immunization, Dental Health (new), WIC, and MCH Services Team (new).

Child Development and Rehabilitation Center:

The mission of CDRC is to *ensure that persons in Oregon with developmental disabilities and other chronic disabling conditions are identified and receive exemplary services through programs of public health, clinical service, education and research*. CDRC serves as the state's Title V Agency for children with special health needs, serves as an education and research center for health professionals, provides interdisciplinary clinical services for persons with developmental disabilities and other special health care needs, and, supports the philosophy of partnership with families, health care providers and the community.

CDRC Administrative staff met in the Fall of 1999 to map out a five-year organizational plan for CDRC. Planning focused on the core areas of OHSU's mission: Education, Health Care, Research, and Outreach, as well as Infrastructure to address internal goals. Goals and activities were identified along with a lead person charged to develop plans to implement these priorities. Next steps in the plan include:

Education

1. Develop cost data on teaching activities
2. Summarize data on current training activities
3. Track the amount of time staff and faculty spend in training activities

Health Care

1. Develop a strategic plan for clinical programs
2. Increase fiscal accountability at the program level
3. Increase access for minority populations
4. Expand mental health services
5. Clarify expectations/roles of clinicians - clinical, administrative, training, research

Research

1. Strengthen and expand the research infrastructure of CDRC
2. Increase funded research and evaluation activities

3. Develop better data sources

Outreach

1. Improve collaboration with other units and programs of OHSU and the community
2. Increase/improve marketing
3. Expand continuing education for community providers
4. Strengthen collaboration of outreach programs

Infrastructure

1. Improve administrative efficiency

State Demographics Population Estimates. Oregon's estimated July 1, 1998 population is 3,267,550 (Center for Population Research and Census, 1999). Oregon's population has increased 15.0% since the last US Decennial Census (April 1, 1990), more than double that of the United States (7.6%). Oregon's population increase during the 1990s is primarily a result of two factors, natural increase (birth minus death) and net migration (people moving to Oregon minus people leaving Oregon). Oregon's population is largely Caucasian but is diversifying rapidly. The Hispanic population is among the fastest growing. Between 1990 and 1994 the Hispanic population grew by more than 30% compared to only 7% for the overall state growth average.

Status of the MCH Population. In 1998, 59,811 pregnancies were recorded in Oregon, of which 75.6% resulted in live births. Less than one percent were fetal deaths and 14,233 (24.0%) were induced abortions. The number of reported induced abortions decreased slightly after a 5.0% increase from 1996 to 1997. Oregon's 1997 fertility rate (63.0 per 1,000 women aged 15-44) has dropped 3.3% since 1990.

Status of the CSHCN population: CDRC estimates that at least 15% of Oregon children under the age of 21 years have special health care needs. The prevalence of

chronic illness and disability is increasing due to advances in science and technology and the resulting longevity. The number of children who received special education services for disabilities has increased 10% from 1995 to 1997 (Oregon Dept. of Education - ODE). Of these children, 12% received services for a severe, low incidence disability including vision and hearing impairments, orthopedic and health impairments, autism, dual sensory impairments and multiple disabilities. As of December 1999, 6,259 children 0 - 5 years were enrolled in Early Intervention (1,768) and Early Childhood Special Education (4,491). The number of children enrolled has increased by 6.4% (more than 400 students) for each of the last three years. Congenital anomalies remain a major contributor to the functional categories above. In 1998, 623 (1.4%) of 45,228 live births were associated with congenital anomalies.

In 1999, CDRC provided tertiary level evaluation and management services to 7158 children and young adults, a 5% increase since 1998. Services provided through CaCoon, the Care Coordination Program administered by CDRC, have increased by 60% from 1994-1998.

Families of color experience a disproportionate rate of disabilities. CaCoon reported 1,923 contacts to 335 Hispanic children and their families during 1999. This number represents 23% of the CaCoon Nurses' caseload, contrasted with about 15% of the total infant and child population who are classified as Hispanic. In some counties more than 50% of the families followed by the Nurses are of Hispanic origin.

Also, families in poverty experience a higher rate of disabilities. The Oregon Health Plan (OHP), a Section 1115 waiver for mandatory managed care for the Medicaid population, currently enrolls almost 8,400 SSI-eligible, foster care, blind and disabled Oregonians. Approximately 11% of those enrolled are children. During 1999, 70% of children less

than 21 years of age visited by the CaCoon Nurses received their health insurance through Medicaid. According to the Social Security Administration report, 6,237 children were receiving SSI as of December 1999.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Oregon Title V Agency. Oregon's Title V Agency is the Oregon Health Division (OHD), a division of the Oregon Department of Human Services under the Governor of Oregon. The OHD is located in Portland, Oregon's largest city. Important partners of the OHD in carrying out the mission of Title V are the thirty-four local health departments (LHDs) and the Child Development and Rehabilitation Center (CDRC) at the OHSU. Organizational charts for the OHD, CCFH, and CDRC are provided in Section 5.3, Support Documents. The Title V Director, Donalda Dodson, R.N., M.P.H., serves an Assistant Administrator of the Oregon Health Division and as Director of the Center for Child and Family Health (CCFH). The OHD-CCFH delivers its programs serving the MCH population through county health departments, other state and local partnerships, and coordination with the CSHCN program at CDRC.

Children with Special Health Care Needs Program. Services for children with special health needs (CSHCN) are met through the joint efforts of the OHD and the CDRC at OHSU. Under state legislative mandates, the OHD has responsibility to support all families in their effort to care for family members including those with disability or chronic illness. The CDRC (ORS 444.110) has responsibility to provide services to children with special health care needs. The Federal-State Block Grant partnership is strengthened by the participation of the CDRC Director, Clifford (Jerry) Sells, M.D., M.P.H., on important state and national committees and boards. These include: member

of the Association of Maternal and Child Health Programs (AMCHP) Board of Directors; one of four pediatricians working with the American Board of Pediatrics to develop Boards in Neurodevelopmental Pediatrics.

1.5.1.2 Program Capacity

State MCH Programs and Services. The OHD is responsible for collaborating and coordinating its programs and services with other public and private agencies committed to the health of women, children, and families. Federally funded programs, such as Family Planning (Title X), Immunization (CDC), and WIC (USDA), are within the authority of the Title V Director and have close programmatic ties with Title V programs. The organizational structure assures cooperation among all programs providing services and funding to local health departments and primary care service agencies. The CCFH continues to have close working relationships with other OHD offices committed to working in research, epidemiology, community health and primary care, and minority issues. CCFH also collaborates extensively with other agencies working on issues affecting families and children, such as the Oregon Department of Education Early Intervention and Special Education programs, the Oregon Commission on Children and Families, the Office of Medical Assistance Programs (OMAP - Title XIX Agency), the Office for Alcohol and Drug Abuse Prevention, Oregon Mental Health Services Division, and Adult and Family Services.

The CCFH is involved in multiple activities to increase the oral health and prevent caries among children. In FY 2000, a federal-state funding partnership created the support for a State Dental Director, H. Whitney Payne, Jr., D.D.S., M.P.H., a Commissioned Corps officer in the US Public Health Service, to evaluate oral health status and facilitate planning to improve oral health systems for children and children with special health care needs. To provide health consultation and education to providers, the OHD is

participating in the Planning and Fluoridation Systems Development Initiative to help five communities plan fluoridation campaigns. CCFH has a partnership with OMAP to create, staff, and promote oral health through the formation of an Early Childhood Caries Prevention Coalition. The outcomes for the Coalition's efforts will: 1) support the efforts of the State Dental Director and, 2) facilitate dental and medical provider education for early children caries prevention.

Oregon's MCH Hotline (SafeNet) was established in April 1991, and is funded jointly by the Title V and Title XIX Agencies. Both agencies have representatives on the Hotline Advisory Board and are active in monitoring and expanding the services offered by the Hotline. The service is provided through an interagency agreement with Multnomah County Health Department and Office of Medical Assistance Programs. SafeNet has continued to be an excellent support service for MCH Programs on a statewide basis and continues to provide a mechanism to link clients with public and private health services.

Development of Assessment Capacity

The CCFH is developing an MCH Monitoring System with support from the State Systems Development Initiative (SSDI) grant and participation by the CDRC. This monitoring system will provide information at the county and state levels for assessing trends in health status, developing strategies for health promotion and disease prevention, and creating or modifying public health program interventions. The foundation of the MCH Monitoring System is a multi-year base of MCHB and State performance measures and health status indicators. The MCH Monitoring System will get the necessary data from the Women's and Children's Health Data System (WCHDS) and the Outcome Assessment through Systems of Integrated Surveillance (OASIS), both described below, as well as from CDRC and other DHS databases.

The WCHDS Integration Project is a client-based system designed to collect local health department encounter data for programs administered by CCFH. The WCHDS Project will roll out the WIC, and Immunization modules to local health departments in late 2000, along with other modules for clinical programs such as perinatal, family planning, and home visiting programs, Babies First! and CaCoon.

The Oregon Health Division has a number of data improvement projects underway that include the surveillance and data needs of CCFH as well as other OHD Centers. OASIS is another project initially funded by the CDC to make existing data sets available for integrated analysis. The first phase of this project concentrated on the migration of STD, TB and HIV databases into a single "data warehouse." Data tables from other programs are being added to OASIS and will be linked in later phases to improve OHD's capacity to conduct analysis across categorical programs and articulate the relationships among behavioral risk, mortality, morbidity, and other health outcomes. Current and near-future additions to OASIS include vital data on births, deaths, fetal deaths, and induced abortions; the first year's results from Oregon's Perinatal Risk Assessment Monitoring System (PRAMS); data extracts from Medicaid and the Children's Health Insurance Plan (CHIP); the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) data tables.

The Information For Health Outcomes (InFHO) Unit projects are intended to improve and expand the capacity to link databases to better assess the health status of specific population groups. The Unit's Public Health Medicaid Assessment Initiative, funded by a five-year grant from CDC, has developed a partnership with OMAP, to facilitate the availability of and use of data about the health risks, health status, preventive services, and clinical outcomes of Oregonians on Medicaid. This project, among other activities, will

link the Medicaid client data with birth certificates to provide information about access to services and disparity in service delivery.

The MCH Data Systems Coordinator, funded by the SSDI grant mentioned above, has begun working with management of WCHDS, OASIS, and InFHO to assure that MCH data needs are met by these developing systems and that those data are turned into assessment and assurance information that is accessible by and useful to local, state, and federal MCH professionals.

MCH Epidemiology

An MCH epidemiologist is working in CCFH under a grant from the Centers for Disease Control (CDC), to provide consultation and surveillance of MCH population health status to OHD programs and other local and state organizations. This position has improved the CCFH capacity to assess this population and develop valid data sources. The MCH Epidemiologist (MCHE) has taken a lead role in implementing PRAMS (Pregnancy Risk Assessment Monitoring System) in Oregon. The first survey results will be available in the Summer of 2000. PRAMS will enhance the Center's ability to identify problems, and develop and track health status indicators and performance measures. The MCH epidemiologist is working on SIDS, breastfeeding, and immunization projects, in addition to improving the MCH data infrastructure, to allow CCFH to improve its ability to use data to develop policy and assess program performance. The MCH epidemiologist is leading the efforts to create a surveillance system and will be instrumental in assuring the institutionalization of surveillance in the Center for Child and Family Health.

Children with Special Health Care Needs Program Capacity.

CDRC is a statewide service program that provides health and rehabilitative care for children with special health needs and their families. CDRC includes a tertiary clinical

program, the Title V Oregon Services for Children with Special Health Needs (OSCSHN), and the Oregon Institute on Disability and Development which includes the Center on Self-Determination. The CDRC has offices in Portland and Eugene. A variety of tertiary care clinics are offered at both the Portland and Eugene offices. These clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the University Affiliated Program at the University of Oregon.

The CDRC also administers two community-based programs for CSHN. CaCoon – Care Coordination – is an exemplary statewide care coordination program that provides public health nursing services in communities where families live. The Community Connections Network (CCN) coordinates community clinics in twelve sites.

CDRC provides training for a broad array of health professions from more than 14 speciality disciplines. Also, every year CDRC faculty and staff provide extensive continuing education to practicing professionals, bringing them up-to-date information on new developments in special health needs and disabilities.

1.5.1.3 Other Capacity

Other Capacity - Maternal and Child Health Programs. The OHD Center for Child and Family Health employs approximately 100 permanent and temporary staff, with expertise and skills in all program areas. The CCFH organization chart is in Section 5.3. The direct delivery of MCH programs is provided by staff at local health departments, funded by Title V and other federal and state funds through grants to counties. There are approximately 1,700 county public health staff persons in Oregon, not including staff at non-profit or tribal health centers. This includes 28 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professional staff in Oregon LHDs. The OHD Office of Community Health Services

assists in recruitment and orientation of local agency administrators. This Office coordinates the OHD local Agency Review process on a three-year on-site cycle to provide consultation for local public health services.

Local or county health departments (LHD) provide direct and enabling services, as well as comprehensive health education, promotion, referral, and information to their communities. Programs for the Title V population are funded through Title V in combination with state general funds, foundation grants, and local funds, in addition to other federal grants. County health department activities conducted in cooperation with financial and technical assistance from CCFH are highlighted below.

County Health Department Service Delivery

Perinatal Program: Prenatal care in county health departments has been gradually shifting the focus from direct to enabling services as prenatal care is provided to fewer clients and screening, assessment, and case management to more women. A newly developed population-based project which focuses on increasing early access to prenatal care is Oregon MothersCare (OMC). In FY 2000, a grant from the March of Dimes (MOD) allowed OMC to be implemented in three local health department and two community-based sites as well as another local health department with the assistance of a Health Start grant. This program is slated for statewide expansion in FY 2001 through the continuation of the MOD grant, additional funding from the Office of Medical Assistance Program (OMAP) and the optional use of state block grant funding by some county health departments. An OMC site is contracted by OHD to provide outreach, health plan enrollment, and information and referrals. Oregon MothersCare increases consumer, community, provider, facility, and agency responsibility for adequate perinatal care and creates partnerships and collaboration to find solutions for assuring women receive first trimester care.

Babies First!: "Babies First!" is a statewide primary and secondary prevention program. Its goal is to identify high risk infants (as defined by risk factors associated with poor physical and emotional health/developmental outcomes) and then to improve the health outcome of these vulnerable children through prevention or early identification of problems. OHD provides state general fund grants to LHDs for public health nurse visits. The visits include screening and assessment services to monitor growth, physical and emotional health and dental status, immunization status, and providing standardized screening for vision and hearing, developmental status, maternal-infant interaction, and family assessment. The public health nurse visiting the family identifies family strengths and weaknesses, assists the family to improve parenting skills, develop appropriate expectations regarding growth and development, and improve access to and utilization of other community agencies including health care. A statewide data collection system allows for the collection of both demographic and outcome data. The system also provides Medicaid billing of targeted case management services. "Babies First!" was implemented in July 1990 with a phase in of all county health departments over a two-year period. Approximately 9,000 infants received nearly 25,000 public health nursing home visits in 1998-99.

Breastfeeding Promotion: Representatives from the Oregon Health Division as well as representatives from county health departments serve on the Oregon Partners in Breastfeeding Promotion coalition. The primary focus of the coalition in 1999 was getting breastfeeding legislation passed. On June 23, 1999, Oregon's Governor Kitzhaber signed SB 744 which states that a woman may breastfeed her child in a public place. He also signed an Executive Order that all State of Oregon employees will be provided with adequate facilities for expressing milk or breastfeeding and that reasonable efforts will be made to meet this. The Coalition will be working on expanding the Breastfeeding legislation in the 2001 Legislative Session. Several counties have developed a breastfeeding plan for their community. Linn and Benton Counties will be using OHD

Breastfeeding Friendly Employer packets with mothers and businesses. Josephine and Jackson Counties will be developing an in-house breastfeeding policy as well as work with employers on becoming breastfeeding friendly. Deschutes County will be developing an internal breastfeeding policy and set aside space for expressing breastmilk. Klamath County will increase communication with their hospital. Eastern Oregon (Wasco, Sherman, Grant, and Baker Counties) will be planning a breastfeeding conference in Pendleton and working on growing their coalition. Multnomah, Clatsop, and Marion Counties will address county policies, have their task force take action, work with hospital breastfeeding advisory board, and make pumps available to employers for six months. Curry County will provide WIC pumps for clients, work with their hospital on becoming breastfeeding friendly, and address support needs for a peer counselor group.

Injury Prevention: Though the lead on injury prevention has been relocated in the Center for Disease Prevention and Epidemiology, Title V funds continue to support the Child Injury Prevention Coordinator and works closely to achieve OHD's injury prevention goals. Injury prevention activities at the local level include public education and awareness on use and correct use of child safety seats through: hands-on inspection clinics throughout Oregon, quarterly mailings, and public awareness campaigns. Local health department staff has been trained in the proper installation of child safety seats. The child safety seat voucher system located at county health departments provides vouchers for parents to purchase car seats for infants and children. The State Technical Assistance Team (STAT) has been working with local health departments through its efforts with the multi-disciplinary teams and child fatality review teams in each county. County health department officials and public health nurses sit on these teams. STAT has provided technical assistance and has conferred with the teams regarding child abuse and neglect issues. STAT's program coordinator is on loan from the child protective service agency, the State Office for Services to Children and Families, and has conducted training to local

health and mental health professionals in counties in the identification and reporting of child abuse and neglect.

Nutrition Education and Promotion: Local health departments promote nutrition education and promotion through their WIC programs which identify clients needing referrals based on the client's health history and diet assessment. People who need services are referred to TANF, food stamps and other food resources, drug and alcohol counseling, smoking cessation programs, parenting, breastfeeding support, and Head Start programs. Many WIC agencies partner with other public health programs to maximize nutrition education and promotion. For example, Clackamas County WIC collaborates with Healthy Start in providing referrals and training. All WIC local agencies identify children needing immunizations through the Immunization tracking system and refer these children to the appropriate provider. Columbia County WIC cosponsored a nutrition education program with the Oregon Dairy Council. Washington County presented "Great Beginning" a nutrition education curriculum for teens in the Washington County High Schools. Both urban and rural programs are providing increased access to public health and WIC services. Many health departments offer clinics at multiple sites and evening and weekend hours to provide easy access for women, infants, and children, as well as in multiple languages. Multnomah County WIC offers classes in Spanish, English, Russian, Vietnamese, and Cantonese as well as American Sign Language.

School Based Health Centers: Local health departments are involved in many adjunct activities that support adolescent health and wellness. Many counties participate in local planning processes with school districts in health education, curriculum development and the planning of school health services or school-based health centers (SBHCs). Thirteen counties currently participate in the operation of state certfied SBHCs. Counties have also created special programs or program settings to improve outreach for specifiic or categorical services such as access to family planning, immunizations and other preventive health services. Counties have also brought increased attention and staff training

opportuntities in areas such as nutritional needs of youth, physical activity and eating disorders among the adolescent population. County public health staff routinely sit on community planning groups and sometimes participate directly in the implementation or delivery of programs in the areas of tobacco use and teen pregnancy prevention.

Other Capacity - Children With Special Health Care Needs Program.

The CDRC employs 219 permanent and temporary faculty, classified and administrative staff; 190 are located in Portland at OHSU and 29 work at the CDRC Regional Office on the University of Oregon campus in Eugene.

Many staff have multiple responsibilites including clinical, teaching, outreach and research. Dr. Jerry Sells continues as the Director of the CDRC. In December 1999, Catherine A. Renken, R.N., M.P.H., was appointed as the Assistant Director of OSCSHN.

Twenty staff (10.5 FTE) receive salary support from the Title V Block Grant. Most staff work part time on OSCSHN programs. The Program Managers have experience with CSHN and/or graduate level education in a relevant field. The Title V program includes a developmental pediatrician, registered nurses with public health experience, an evaluation consultant, parent consultants, a social worker, a nutrition consultant and a cultural competency coordinator. There are five support staff with experience in financial counseling and program operations. Some administrative staff, some business office and data management staff receive partial support through the Block Grant administrative allowance. OSCSHN also supports a small percent of CDRC clinic nurses, social workers and program support to provide case management and parent education services to children and families seen through the CDRC tertiary specialty clinics.

The OHD and CDRC have jointly recruited and hired a Genetics Coordinator. This position is responsible for providing leadership to improve the quality, accessibility and utilization of genetics services in Oregon and to promote the thical use of emreging genetic technologies. The Coordinator will work with OHD and CDRC to integrate genetic services into the broad scope of public health programs coordinated by Title V and assure that all activities address children with special health care needs, women, and adolescents through the life cycle.

CDRC sponsors interdisciplinary clinics in thirteen communities across the state through the Community Connections Network (CCN). Eighteen pediatricians or family practice physicians provide the medical piece to the clinics; one orthopedic surgeon and one psychiatrist also participate. CCN funds a clinic coordinator at each site to provide local support for the program (a total of 2.2 FTE). In addition, through the CaCoon Program, CDRC supports 12 public health nurses to provide services to families in all 36 counties of the state.

Location	Number of Staff	
Portland	190	
Eugene	28	
Medford	1	
CaCoon PHN's	38	(11.88 FTE)
CCN Contracted Staff	26	

Number and role of parents of special needs children: CDRC has collaborated with Family Voices in Oregon, a network of over 400 families and their professional partners coordinated by two parents. The OSCSHN program partnered with state and national Family Voices organizations on the Family Voices/Brandeis University managed care survey, “Your Voice Counts.” Oregon Family Voices coordinators have worked with CDRC to address managed care issues and policies, including participation in local and national committees addressing health care reform, and follow-up activities with Office of

Medical Assistance Programs (OMAP) related to the OHP Parent Satisfaction Survey. Additional joint efforts with the state coordinators include:

1. addressing CSHCN on the Doernbecher Children's Hospital (DCH)/CDRC Transition Work Group on Family Centered Care and the Family Advisory Committee for DCH and its CDRC clinics,
2. planning a statewide parent-to-parent program with the Coalition in Oregon for Parent Education (COPE - Oregon's parent training initiative),
3. working with the Task Force for Quality Issues for Children with Special Needs to identify children with special needs in both public and private health care systems and to implement the state action plan developed at MCHB Tri-Regional meetings,
4. collaborating with CaCoon nurse consultants to disseminate managed care information to families throughout the state, and
5. participating in joint training events for public health nurses, community providers and families sponsored by CaCoon and CCN, Shriners Hospital and OMAP.

The Oregon Office on Disability and Health, a joint project of OHD, CDRC and the Oregon Health Policy Institute, is located at CDRC. People with disabilities and parents of CSHCN comprise over 50% of the project's Advisory Council and work committees.

CDRC employs people with disabilities and parents of children with special needs, including a program evaluator, program support and project coordination. A parent administers the gift fund that provides payment to families for equipment or services not covered under the OSCSHN program or insurance. Activities supported by OSCSHN and programs led by OSCSHN staff in cooperation with other CDRC faculty and community providers are highlighted below.

CAre COordinatiON (CaCoon): CaCoon is a statewide program for families who have children birth through 20 with special health or developmental needs. CaCoon partners with county health departments in Oregon to provide public health nursing services in the communities where these families live. CaCoon services may include home visits, family and child health assessments, developmental screening, emotional support, coordination between family and health care or social service agencies, consultation and collaboration, and advocacy. Also, nurses provide parent education for managing health interventions such as special feeding techniques for a child with a cleft palate or intermittent catheterization for a child with Spina Bifida. In all counties CaCoon nurses participate on county councils including the Early Intervention Advisory Groups to help facilitate medical educational collaboration and assure that the health needs of this population are identified and addressed.

The CaCoon program offers in depth training for the CaCoon nurses a minimum of twice a year. Trainings focus on topics such as specific disabilities, practice guidelines, screening and assessment procedures, and other topics identified by the nurses. CaCoon staff at CDRC provide consultation and technical assistance to the nurses on an ongoing basis.

Community Connections Network (CCN): CCN is a network of clinics across Oregon that addresses the needs of the whole child. The philosophy of the program is to provide quality community-based, family-centered, culturally appropriate services in a coordinated manner for children and their families as close to where they live as possible. It is intended to improve Oregon's services for CSHN (0-21) in the more rural areas of the state. This is done by utilizing local community providers who provide multi disciplinary evaluation and assessment clinics for children and families for whom there are unresolved medical issues, educational, and/or social service concerns and for whom progress is not as expected.

CCN clinics are located in twelve sites serving children living in 25 of the most rural counties of Oregon.

CCN is a collaborative program: a partnership between the CDRC and communities; between managed care and local providers; between health and education; between public and private entities. Communities participate by contributing the space as well as the education, public and mental health, and therapy professionals needed to conduct the evaluations and by coordinating recommendations resulting from the clinic visits.

Although the CCN is a system or network of clinics with common elements in each community, it differs in each location. Since the resources, needs, personnel, and families differ in each community, CCN is unique in each site. Each community designed their own program and whom it would serve. Outcomes for the clinics include improving access to services close to where people live and increasing the capacity, skills and expertise, of providers across the state.

CDRC Tertiary Care Clinics: CDRC administers tertiary level clinics in Eugene and Portland. Interdisciplinary teams provide diagnostic assessments, consultation, and management for children and young adults with established or suspected disabilities, developmental or behavioral concerns. Some of the clinical programs are "unique," providing a service that cannot be found elsewhere in Oregon. These include the Metabolic, Hemophilia, Genetics and Assistive Technology clinics.

There were 7,158 clinic visits in Portland and Eugene in FY99. The number of recorded clinic visits to the Eugene office includes visits to CDRC outreach clinics in Medford, Klamath Falls and Roseburg. A CDRC developmental pediatrician, physical therapist and occupational therapist provide monthly clinics in Medford (10-12 children/families each

clinic) and biannual clinics in Klamath Falls (12-14 children/families each clinic). A developmental pediatrician attends an every other month clinic in Roseburg (4-7 children/families each clinic). These clinics involve provision of direct services and collaboration with and training of community professionals. The Medford clinics are held at Rogue Valley Medical Center; the Klamath Falls clinics at the EI/ECSE office/preschool; and the Roseburg clinic at a primary care pediatric office. Roseburg and possibly Medford will be transitioned to CCN sites in the future. The clinics in Klamath Falls are complementary and supportive to the CCN clinics in that community.

The specialty clinics at CDRC have been impacted by the Oregon Health Plan (OHP) and the move to managed care. When OHP began in 1994, CDRC estimated that two-thirds of the fee-for-service Medicaid clients would be changed to managed care and that these children would not be referred to any providers, including CDRC, outside of their own system. The projection proved incorrect and CDRC actually experienced an increase in the number of visits for the Medicaid population. Primary care physicians in the managed care plans have not shown any reluctance to refer their patients to CDRC. In fact, CDRC clinicians report the number of children with complex behavioral, social and physical conditions are increasing and believe primary care physicians are treating the less complex child and referring the more complex children to CDRC clinicians who have the expertise needed for these patients.

Unfortunately, CDRC clinics are being paid less for services by OHP and by commercial managed care, indemnity plans. CDRC's reimbursement rate slipped from an overall rate of 80% in FY92 to 64% in FY99. Reimbursement rates for individual clinician charges are as low as 16%; reimbursement rates for a multi-discipline clinic are as low as 32%. Contracts with payors are negotiated with cost containment as a goal, but CDRC is at a disadvantage because of the population served. The examination and evaluation of the

special needs child is time-consuming and CDRC is unable to increase the number of patients without increasing its costs proportionally.

Historically, OSCSHN has supported the tertiary clinical program at CDRC as an important component in the care of children with complex special health needs. OSCSHN continues this practice. In 1997, Dr. Sells, CDRC Director, convened a work group to define utilization of the Title V Block Grant. After many months of thoughtful discussions, the group recommended a plan to Dr. Sells. The plan outlined a funding formula for the Block Grant support of the CDRC clinics. The formula-based allocation to specific clinics was based on the "uniqueness" of the service, the core disciplines necessary to provide the service and the reported number of services to OSCSHN eligible children during the last year. The formula also included support for enabling services, e.g., case management, family/parent education, provided by clinic nurses, social workers and support staff. Support for OSCSHN in future years will be based on the number of services to OSCSHN eligible children in the previous year. The recommendations were accepted and implemented in FY99.

OSCSHN Financial Assistance Program: OSCSHN provides financial assistance to families who meet the financial eligibility criteria at three times the federal poverty level and whose child has a qualifying medical diagnosis. Financial counselors screen families to determine program eligibility and make referrals to OHP, CHIP and the Family Health Insurance Program (FHIAP) when appropriate. Some of the OSCSHN covered services are hospitalizations, outpatient services, multi-disciplinary team evaluations and management, physical therapy, occupational therapy, special supplies, ancillary services, transportation and lodging.

CDRC/ODE Interagency Team (COIT): Since 1992, key people from the Oregon Department of Education (ODE) and the CDRC have been meeting on a monthly basis to revise, update, monitor and operationalize the interagency agreement between the two agencies. In addition, the team addresses issues that cross health and education for children with disabilities. Issues addressed recently include adolescents transitioning to adulthood and working with NICU's as babies move to the community. As issues are addressed, individuals with relevant expertise are invited to the meetings to discuss, brainstorm and resolve problems.

Community Outreach and Action for Children who are Hispanic (COACH):

COACH is a four year CISS grant project funded by MCHB. The project has two goals:

1. to increase access to and utilization of appropriate health and related services for CSHN in the Hispanic community of Marion County, and
2. to increase cultural competence of care providers and the organizational service systems that serve families of Hispanic origin.

To accomplish these goals, a Promotora/outreach worker was hired in Marion County to work with the CaCoon nurse. The Promotora and nurse share a caseload of families with the Promotora providing case management and the nurse providing health related services including health education.

Multi-cultural experts are working to address the cultural competency goal. A cultural competence plan with action steps has been developed and several training opportunities and dissemination activities to build cultural competency have taken place. Plans for the fourth and final year of the project include replicating the Promotora/ outreach model in other Oregon counties.

Multi-Cultural Task Force (MCTF): The MCTF at CDRC was originally designed to advise three projects that had a cultural focus. Only one, COACH, is still ongoing, so the focus has shifted a little. The group includes CDRC, OHSU staff as well as community people and is focused on improving the cultural competency of staff at CDRC as well as in the community programs. In addition, the task force advises other aspects of the COACH project.

Adolescent Transition Team: In looking at the issue of adolescents transitioning to adulthood, a team has been focusing on finding ways to have health be a part of transition planning in schools, job placement and also from pediatric to adult providers. Involved in this effort is the Health Division, CDRC, Center on Self-Determination, Shriners, OHSU.

Nutrition Consultative Services for CSHCN: Nutrition services for CSHN are provided on a consultative basis through technical assistance to community-based practitioners and strategic planning to ensure that individuals with special needs receive nutrition services. A needs assessment was conducted to determine current nutrition services and to determine which providers of nutrition services are used in addressing the nutrition needs of CSHN. An e-mail network has been established using a private list-serv to link Registered Dietitians working with CSHN. Also, in coordination with the WIC program, the critical elements of nutrition care of the low birth weight infant are being identified and efforts to establish guidelines for appropriate formula and feeding recommendations care is underway.

Medical Home Task Force: During the Title V Tri-Regional meeting in November 1999, the Oregon state team developed a plan to define more clearly the concept of the medical home and initiated a discussion regarding the activities the team wanted to accomplish. As a result of that discussion, the state team was expanded to include other

CDRC staff members, the president and president elect of the Oregon Pediatric Society, the Oregon CATCH representative, other pediatricians in the state and another parent. The group has met on a monthly basis and is finalizing plans to complete parent and physician surveys and to participate with Shriners Hospital in the American Academy of Pediatrics' Medical Home training program.

Center on Self-Determination: The mission of the OHSU Center on Self-Determination is to identify, develop, validate and communicate policies and practices that promote the self-determination of people with and without disabilities. The Center is staffed by 17 individuals with expertise in a wide range of community and disability issues, applied research, data management, publication and outreach experience. The Center administers 18 projects including Community Solutions, an MCHB Healthy and Ready to Work Project. A complete list of the projects is included in Appendix A.

1.5.2 State Agency Coordination

The OHD, as the state Title V Agency, continues to work closely with the OMAP, which is the agency responsible for overall administration of Medicaid through the OHP. The OHD maintains an agreement with OMAP for a community immunization program and to purchase vaccines for children enrolled in CHIP, for joint management of the Section 1115 Demonstration Family Planning Expansion Project, and for the MCH Hotline, SafeNet, which is contracted to the Multnomah County Health Department. Other financial collaborations include funding for the Dental Program and possibly for the Genetics Program.

The OHD and CDRC have a long history of working together toward common goals of assessment, program implementation, training and health policy development for the MCH population including CSHN. Examples of collaborative efforts include:

Babies First! and CaCoon

Babies First! and CaCoon have always coordinated program components and procedures. Both programs employ county health department public health nurses to implement the programs at the local level. Common developmental screening tools and data reporting forms are used. The OHD's statewide data system allows for the collection of demographic and outcome data and provides needed information for monitoring and evaluating both programs. The system also provides Medicaid billing for targeted case management services. Joint trainings are presented for the nurses and program managers continue to collaborate on common issues.

Adolescent Transitioning

The Adolescent Health Manager from the OHD participates on the Adolescent Transition Team at CDRC. Efforts are being made to increase participation of adolescents with disabilities in school-based centers.

Early Childhood Service System

The Child Health Consultant in CCFH is assigned to be a part of the Interagency Coordinating Team charged by the Governor to implement an Early Childhood System of Care in Oregon. She also represents CDRC on the team. The OHD data system, WCHDS, has been selected as the individual data system as well as housing the data warehouse for the Early Childhood programs. CDRC staff are participating in the planning to establish this expanded system. CDRC and OHD staff have dedicated many hours to the planning and implementation of this system.

Newborn Hearing Screening

OHD and CDRC partnered with other agencies to draft and advocate for the newborn hearing bill. The bill passed and as of July 1, 2000, all hospitals with more than 200 live births per year are required to provide hearing screening tests to all babies born in their hospitals. The CDRC Director participates on the committee charged with implementing the legislation.

Metabolic Screening

The OHD, through the OHD Public Health Laboratory, provides newborn metabolic screening to all Oregon infants. Newborn screening follow-up, program consultation, quality assurance and education are provided by CDRC. Through this agreement, all infants who are suspected of having metabolic problems are referred to CDRC for follow-up.

Statewide Genetics Coordinator and Genetics Planning Grant

OHD and CDRC have recently hired a Statewide Genetics Coordinator who will begin working in September. This position is jointly funded by OHD, CDRC and the state Medicaid agency. The position is responsible for providing leadership to improve the quality, accessibility and utilization of genetics services in Oregon. Oregon was successful in recently receiving the state Genetics Planning Grant. This grant will allow us to hire a community planner who will work with the state genetics coordinator to develop a state genetics plan.

Other Title V Activities

OHD and CDRC staff work together on Title V activities including the MCH needs assessment, the block grant report and application, SafeNet and other committees and task forces.

Toll-free Telephone Numbers: The state's Maternal & Child Health hotline, SafeNet, is designed to link low income Oregon residents with health care services in their communities; assist in identifying and prioritizing needs of callers with immediate, multiple health care concerns; match provider callers with appropriate information concerning options; track and document service gaps; and provide follow-up and advocacy to insure that clients statewide are able to access available services. Program supporters and staff are dedicated to maintaining a strong community-based service network for families. The primary source for SafeNet outreach is through Medicaid card messages and inserts (WIC,

prenatal, flu, and dental). Other SafeNet outreach occurs through statewide Yellow Pages advertising, AFS offices, OHP staff, local health departments, private providers, managed care plans and social service agencies. Special advertising campaigns designed to move particular target audiences to call SafeNet for particular time-sensitive information is conducted periodically. Discussion is underway to utilize SafeNet as a part of other nutrition and food assistance programs such as in Adult and Family Services. This type of partnership building and coordination assist families in meeting their total health care needs.

Automated databases track multiple presenting needs, client demographics, and call volume by day and time. Data is collected by presenting need, county, publicity, and percent of poverty level, age, gender, ethnicity, and referral. Management reports are published on a semiannual basis and used to identify the primary concerns of users of the hotline, to evaluate and alter the scope for the information and referral materials.

Interagency and Intra-agency Coordination Efforts: The OHD collaborates with the following state agencies to facilitate protection and prevention efforts for Oregon's MCH population.

OHD Interagency Coordination:

1) *Adult and Family Services*: Community-Based Application Assistance project (to expand access to OHP and early prenatal care), Students Today Aren't Ready for Sex (STARS) Abstinence Program, Title V Abstinence Program, Teen Pregnancy Prevention
2) *Office of Medical Assistance Programs*: Lead Screening, Community-Based Application Assistance Project, Dental Health Services, Preschool and Adolescent Immunization, Vaccine for CHIP Children, Family Planning Expansion Project,

School-Based Health Centers, CHIP, VISTA Health Links, Oregon MothersCare, Maternity Case Management, Babies First! and CaCoon

3) *Services for Children and Families*: STAT - State Technical Assistance Team/ Child Fatality Review, Fetal Alcohol Affected Project
4) *Office of Alcohol and Drug Abuse Prevention*: Youth Risk Behavior Survey
5) *Mental Health Division:* Fragile Children Program, Suicide Prevention
6) *State Fire Marshal:* SafeKids Program
7) *Oregon Commission on Children and Families*: Oregon's Child Everyone's Business Campaign, Oregon MothersCare, African American Infant Mortality Project, Oregon's Healthy Start, Lighted Schools Project, Finance Project, STARS Abstinence Program

OHD Intra-Agency Coordination:

The Title V agency coordinates programs within the OHD and with other providers and organizations to achieve its goals.

1) The Immunization ALERT program works closely with the Oregon Health Systems In Collaboration (OHSIC) to build a statewide immunization registry among private and public providers.
2) WIC and Immunization have joined in a coordinated effort to refer WIC and perinatal clients to appropriate immunization services for mothers, infants and preschool children.
3) The Breastfeeding Initiative is a program coordinated between WIC and Child Health nutritionists to improve the nutritional and healthy status of infants.
4) Oregon's MothersCare is an initiative to build partnerships to streamline, coordinate and promote access to early prenatal care through coordination of referral systems which link women to the state toll-free hotline (SafeNet), pregnancy test sites, local health departments, OHP (Medicaid), Maternity Case Management, WIC and other agencies that provide prenatal services.

5) The School-Based Health Center, Suicide Prevention and Immunization programs collaborated on a communications and marketing package that were sent to primary care physicians linking changes in the state immunization laws to opportunities in providing a more comprehensive preventive health visit for adolescents.
6) The Title V and Title XIX agencies, with other private and public providers, participate on joint committees to facilitate the coordination of services with common clients.
7) The Childhood Injury Prevention Program, in CDPE, chairs the Area Trauma Advisory Boards to coordinate activities across a variety of public and private organizations.

OHD Interagency Agreements.

The OHD maintains contractual interagency agreements with a number of other agencies. Agreements are reviewed on an annual basis and updated as necessary. Examples of these agreements are described briefly below. Copies of current agreements are on file in the OHD.

1) CDRC is the contract agency to deliver the Title V services to children with special health care needs. The current contract was renegotiated to include certain assurances required by Public Law 101-239. These include assurances not to exceed 10% maximum administrative charges, a requirement of 1989 Maintenance of Effort, to collect data required for needs assessment and to continue the development of a community-based, family-centered, coordinated system of health care for children with special health care needs. The FY 2000 contract includes a provision to establish an infant hearing screening advisory committee to establish standards and recommendations for screening infants, and to participate in Genetics Planning and coordination.
2) The OHD contracts with the State Perinatal Center at Oregon Health Sciences University (OHSU) to provide technical assistance, on-site consultations, chart

reviews, and bimonthly continuing education to the prenatal clinics at LHDs. In addition, it participates as a partner with the OHD to address perinatal technical policy issues for the state.

3) The OHD contracts with the Department of Pediatrics at OHSU to provide medical consultation on newborns who are screened by the Public Health Laboratory. This program consultation involves specific test results as well as laboratory and clinical evaluation policies.
4) The OHD also maintains contractual arrangements through a grant award system with all LHDs. The OHD monitors and evaluates the delivery and quality of services through the review of annual plans submitted to the OHD each year and tri-annual site reviews.
5) The OHD has agreements with a variety of schools to provide a school fluoride rinse program. This includes the provision of fluoride supplies to schools and training programs for teachers, professionals, and volunteers.
6) The OHD has an agreement with the Multnomah County Health Department to conduct grass-roots organizing around the issue of community fluoridation.
7) The Immunization Program contracts with OMAP to improve age-appropriate rates among Medicaid children to 90% by two years of age and implement a plan to promote adolescent immunizations. The Immunization Program also contracts to purchase vaccine to be provided under the Title XXI, Children's Health Insurance Program.

CDRC - Children with Special Health Care Needs Agency Coordination.

CDRC Interagency Coordination Efforts

CDRC continues to strengthen partnerships developed over the years through working interagency agreements with the following agencies.

- Oregon Department of Education
- Services for Children and Families
- Vocational Rehabilitation Division
- Social Security Administration
- Office of Medical Assistance Programs
- Multnomah County Health Services Division

These interagency agreements assure that appropriate care and coordination of care exists within a variety of systems to identify children who qualify for the services of CDRC.

CDRC contracts with 33 county health departments for implementing the CaCoon program and contracts with local physicians and local coordinators at twelve CCN sites. The interdisciplinary teams, at the CCN sites, also include physical therapists, speech/language pathologists, social workers, nurses, mental health professionals and others as needed. These providers are members of the community; their employer donates their time to participate in these clinics.

CDRC works closely with state and county agencies, health care providers, professional organizations, families and family organizations to ensure that systems of care address issues and needs of the special health needs population and to coordinate care of individual children and families. Examples of interagency collaboration are described below.

1) *Office of Medical Assistance (OMAP*): CDRC's Interagency Agreement addresses reimbursement rates for services provided at the CDRC tertiary clinics for children covered by a Medicaid Fee for Service Card. According to this agreement, Medicaid pays additional dollars for the increased costs of serving the medically complex child. The amount reimbursed by OMAP is the actual cost of the evaluation. The percentage of children covered by fee-for-service at CDRC

has decreased from 44% before 1994 to 16% in FY00 as a result of managed care and the OHP.

Other projects include:

- a 1997 Needs Assessment
- issues of quality assurance and standards of care for CSHN
- an inservice for OMAP Managed Care Plan Exceptional Needs Care Coordinators (ENCCs) about CSHN
- ongoing work to enhance collaboration between the ENCCs and CDRC CaCoon nurses.
- the CDRC Director and CDRC developmental pediatricians have participated with OMAP Medical Directors to develop practice guidelines for CSHN and are asked to speak with the group on various topics related to the population.

2) *Oregon Department of Education (ODE)*: Dr. Robert Nickel, Director of CDRC's Regional Service Center in Eugene, and Catherine Renken, represent CDRC on the State Interagency Coordinating Council for Early Intervention/Early Childhood Special Education (SICC). The SICC advises the Governor on issues that relate to young children with developmental disabilities and associated chronic health conditions. It includes representatives from health, mental health, education as well as other state agencies, and parents. Catherine Renken is co-chair of a nursing services subcommittee of the SICC. Recommendations from that group are being followed-up by the CDRC/ODE interagency working group and will be addressed in the CDRC/ODE interagency agreement. CaCoon Nurses participate on the Local Interagency Coordinating Councils. ODE and CDRC have been meeting on a monthly basis for several years to address issues that cross health and education for children with disabilities. Recent topics include early referral from NICUs to community-based programs and adolescent health transitioning. Local schools participate in CCN clinics

by providing psychologists, physical, occupational, and speech therapists and by releasing their teachers and aides to attend clinics, hiring substitutes to cover the classroom responsibilities.

3) *Oregon Pediatric Society (OPS):* The CDRC has maintained a long-standing collaborative relationship with the OPS. Dr. Jerry Sells, CDRC Director, is currently the chair of the OPS Committee on Children with Disabilities (CCWD) and is a member of the OPS Executive Committee. Membership has increased to include pediatricians from all regions of Oregon many of whom now participate in CDRC's CCN Clinics. CDRC staff also have regularly presented at the annual Spring OPS meeting. Most recently, a CDRC staff member who is also co-chair of Family Voices in Oregon, presented information/materials on family support resources. Finally, the members of the CCWD will collaborate with the state planning group on the Medical Home to develop and implement a provider survey.
4) *Oregon Mental Health and Developmental Disabilities (MHDD):* The OSCSHN Assistant Director has represented Title V on the Medically Fragile Children's Unit/ Children's Intensive In-home Services advisory group since the program's start in 1995. An MHDD staff member participates on the interagency team addressing adolescent transitioning and staff present at CDRC conferences.
5) *Vocational Rehabilitation Division (VRD) and the Social Security Administration (SSA):* CDRC, SSA and the Disability Determination Services (DDS) of VRD have worked together for years to educate providers about Childhood SSI eligibility, to outreach to potentially eligible families throughout the state, and to ensure that families who apply for SSI receive information about available services. VRD and SSA staff often present at CaCoon conferences and meet with local groups throughout the state to speak about Childhood SSI. CDRC clinicians do eligibility assessments and are involved in a federally funded DDS project to reevaluate children who have been denied SSI. For many years VRD representatives have participated with CDRC to

assure youth with disabilities receive the services they need to become "healthy and ready to work."

6) *Shriners Hospital for Children:* CDRC and Shriners Hospital continue to collaborate on adolescent health transitioning and medical home issues. A joint survey of Shriners patients is planned to better understand what families want from a medical home. Plans have begun to host the AAP training for physicians on the concept of a medical home. Several CDRC based pediatricians consult and staff regular clinics at the Shriners Hospital.

7) *Oregon Commission on Children and Families (OCCF):* Healthy Start, which is administered by the Commission, uses paraprofessional home visitors to identify families at high risk for child abuse and neglect. CDRC works with the Commission at the state and local levels to avoid duplication and to train all home visitors. The Commission contributed funds to support a recent CaCoon Conference and sent several Healthy Start workers to the training. A unique collaboration to develop a team of a Healthy Start paraprofessional and a CaCoon Nurse is being implemented in two communities with a significant Hispanic population.

8) *Early Childhood System:* For many years CDRC staff has been involved with the Governor and Legislature to develop an early childhood system of services in Oregon. This plan includes a universal home visiting system that would identify children at high risk for social, health, or developmental concerns and help families link to resources. The CDRC Director participates on a legislative appointed task force and other staff take part in other Governor and legislative committees.

9) *Hospital NICUs and Pediatric ICUs:* CDRC has actively worked with hospitals throughout the state to educate case managers, discharge coordinators and social workers about community-based programs for CSHN, including CaCoon, Early Intervention and SSI, and to encourage early referral. Hospital staff have presented at CaCoon Conferences and are often part of the interagency teams which address the

young child. Hospitals around the state are donating space each month for CCN clinics; sometimes they donate staff to help coordinate the clinic.

10) *COPE, Arc of Multnomah County and other Family Organizations:* CDRC participates with these groups to plan a parent-to-parent network for families who have a child with a special need. In addition, CDRC staff members participate on various local task forces and committees such as Arc, United Cerebral Palsy (UCP), early intervention councils, community service clubs, and neighborhood meetings.

11) *Federal, State and Local Projects:* CDRC staff participates on numerous grant projects in various capacities. These include advisory boards, reviewers of printed materials and training. Examples of projects include Measuring Outcomes in Children with Special Health Needs (MOCSHN) at The Providence Child Center; Measuring and Monitoring Project, Utah State University.

12) *Pacific Northwest Regional Genetics Group (PacNoRGG)*

PacNoRGG is a MCHB-funded consortium of genetics services providers, public health professionals, and consumers working to improve genetics services in Alaska, Idaho, Oregon and Washington. Activities are carried out by the volunteer members of eight committees and the PacNoRGG staff. The PacNoRGG staff provides technical assistance to public and private genetics programs in the region. Resources and information useful to policy makers, clinical and laboratory genetics providers, and consumers are identified and disseminated. Linkages to national, regional, and local resources are provided through a frequently used e-mail list, a web site, and a widely distributed newsletter. The network assists public programs and private providers to evaluate and when appropriate integrate new information and technologies into their programs. The region's four state genetics coordinators frequently assist each other both individually and as a group, by exchanging resources, information, and strategies; reviewing and commenting on documents; and collaborating on activities that are most

efficiently undertaken on a multi-state basis. When needed, high quality, expert-authored genetics educational materials are developed and disseminated.

13) *Oregon Regional Hemophilia Center:* The Oregon Regional Hemophilia Treatment Center has been the designated regional hemophilia center in Region X since 1976. The hemophilia program team travels to outlying communities for comprehensive clinics away from Portland. Outreach clinics include medicine, nursing, physical therapy, genetic and social work disciplines. Until 1990, outreach clinics were held in Alaska and Idaho, and in Oregon. Home and school visits were provided to all four states. In 1999, outreach clinics were held in southern Oregon and eastern Oregon (Hermiston and La Grande).

CDRC Intra-agency Coordination Efforts

OSCSHN collaborates with other programs and staff within the CDRC:

1) *Oregon Development and Disability Institute (OIDD):* Cooperation between OIDD, and specifically with the LEND Program, and OSCSHN is naturally facilitated and intensified by the presence of both programs in the same agency. Collaboration is strengthened by a long history of working together toward common goals of training, excellence in service and development of health policy. Collaboration is enhanced by the presence of the OIDD Director on the CDRC Administrative Staff Committee and the OSCSHN Assistant Director acting as interim Nursing Training Director for the OIDD. The faculty provides consultation and mentoring to OSCSHN's community-based CCN teams and CaCoon Nurses, present at Ed-net broadcasts on various topics, and at annual CaCoon and CCN conferences.
2) *OHSU/Doernbecher Children's Hospital:* OHSU faculty has been the primary presenters at conferences. They also participate on key committees such as the Medical Home Task Force and Adolescent Transition Team and the Multi-Cultural Task Force. Dr. Sells serves on the Doernbecher Executive Committee and on the OHSU Presidents Executive Committee.

II. REQUIREMENTS FOR THE ANNUAL REPORT

The Annual Report, the Needs Assessment and the Annual Plan is presented according the Title V Core Public Health Pyramid of Services. Figure 2 provides the illustration of the Pyramid, page 43.

2.1 Annual Expenditures

FY 1999 Report:

The expenditures for FY 1999 are based on expenditures to date (May, 2000) for the period October 1, 1998 to September 30, 1999. The expenditures for the Federal/State Partnership include all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, which are those funds that are not Federal or state General, and are typically from private foundations. The OHD-CCFH programs included in the Federal/State Partnership include:

Pregnant Women:	Perinatal Program (Block Grant and General Funds)
Children <1 year:	Babies First! (General Funds) Newborn Screening (Other Funds - Fees), WIC - food rebates (Other funds), Farmers Market (General Funds)
Children 1-22 years:	Child and Adolescent Health, Injury Prevention, Dental Health and Oral Health, Teen Pregnancy Prevention, Suicide Prevention (mix of Block Grant and General Funds); School Based Health Centers (General Funds and Other Funds - RWJ Making the Grade Program); Immunization (Block Grant portion); Family Planning for 35% of total clients, representing all those less than 21 years (Block Grant and the Family Planning Expansion Project - Other funds).
CSHCN:	CaCoon, Community Connections, OSCHCN Financial Assistance Program (Title V Block Grant, Clinical Fees, mandated state general fund match)

At the time of preparation, the FY 1999 Block Grant expenditures had not yet closed, so all figures are not final.

2.2 Annual Number of Individuals Served

Form 6: The numbers are based upon the newborn screening reporting system maintained by the Oregon Public Health Laboratory. CY 1999 Birth Data is not yet available, so 1998 data is being submitted for this year.

Form 7: The number of individuals served is based on the reporting by county health departments in the Womens and Childrens Health Data System, and by counties with their own data systems. Data is reported for the Perinatal Program (pregnant women), Babies First! (infants <1 and >1 years), and Child and Adolescent programs (children 1-21). The data for children with special health care needs is form CDRC database.

Form 8: The number of deliveries and infants is based upon the number of births for 1999. Title V served is based upon the client reports for Form 7.

Form 9: MCH Toll-Free calls are reported by SafeNet.

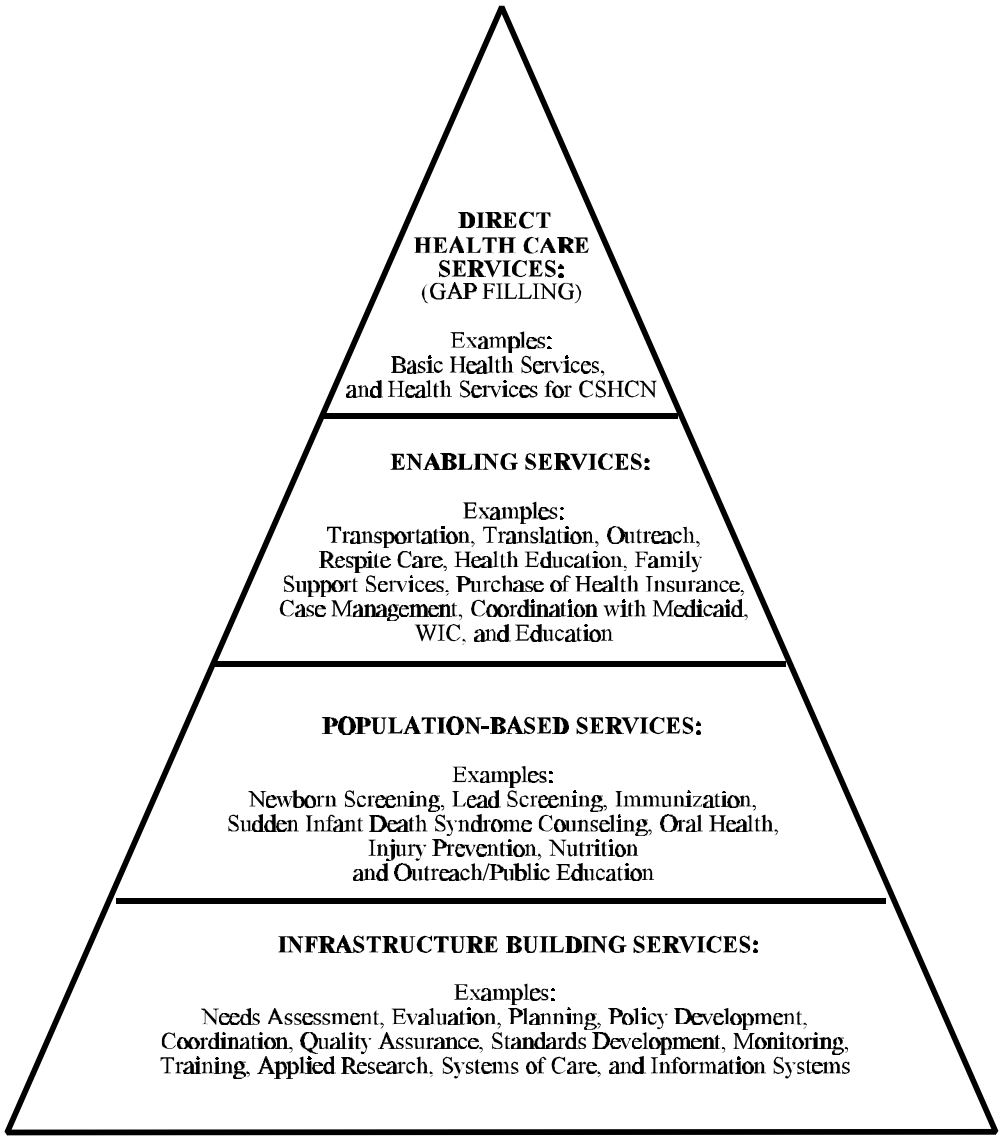
2.3 State Summary Profile

See Form 10 for the FY 99 state summary profile.

The OHD, of the Department of Human Services, administers the Title V Program. The services located in the Title V agency include grants to counties, policy and program development and evaluation, population-based assessment and surveillance, and leadership and coordination of health systems and services for MCH populations, including high-risk pregnant women, infants and children, adolescents, and children with special health care needs.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.4. Progress on Annual Performance Measures

The discussion on the progress made on performance measures is presented for each measure in order of the Pyramid of Services. The summary of activities represents the work of OHD and CDRC in making positive change in each measure.

DIRECT HEALTH CARE

National Goal 1: Percent of SSI beneficiaries receiving services from CSHCN programs

FY 2000 Goal: 7.5% receiving services
FY 98/99 Progress: 7.5% receiving services
Population: CSHCN

- CDRC continued the interagency agreement with VRD (State Vocational Rehabilitation Division) to support our working relationship for the shared population.
- Each SSI applicant, whether approved or denied, received a letter from CDRC listing available state and community resources.
- CDRC developed an agreement with DDS (Disability Determination Services) to provide evaluations to determine SSI eligibility. The Eugene CDRC provided assessments for 33 children. Pediatric examinations were completed on 29 children and 4 children received psychology evaluations. The Portland CDRC provided assessments for 41 children. Pediatric examinations were performed on all 41 children and 25 received psychology evaluations. Other assessments included 1 occupational therapy, 1 speech and 8 audiology evaluations. These numbers represent an increase in referrals to the CDRC for SSI evaluations and the number of disciplines requested to provide assessments.
- OSCSHN administrative staff met with the Program Manager of DDS to discuss data requirements of Title V and to review the current procedure of providing information to our shared population.
- The CDRC/Oregon Department of Education interagency team invited a representative from VRD to attend a meeting to discuss adolescent transition issues.

National Goal 2: Degree (by score) by which the CSHCN Program pays or provides services for uninsured, underinsured or under-served populations

FY 2000 Goal: score 9 out of 9 points
FY 98/99 Progress: scored 9 out of 9 points
Population: CSHCN

- OSCSHN continued to pay for specialty and subspecialty services for families with income levels up to three times the federal poverty. Oregon Health Plan (OHP) eligible patients and those with other insurance coverage also received benefits from OSCSHN for services either not covered or partially covered by their health plans.
- OSCSHN decided to add payment for respite care services to eligible families. The need for respite funding in Oregon is significant and OSCSHN responded by piloting a project to provide financial assistance to families for respite care.
- OSCSHN continued cost management efforts such as paying for services provided through OHSU/CDRC clinics, maintaining agreements with community providers to pay for services at discounted rates and coordinating benefits with health insurance companies and other payers.
- OSCSHN continued the referral process for families to the OHP, Children's Health Insurance Program (CHIP), Family Health Insurance Assistance Program (FHIAP) and SSI.
- OSCSHN developed a formula for support for the CDRC specialty clinics. The allocation is based on the uniqueness of the clinic service, the core disciplines involved and the actual services provided to OSCSHN sponsored clients.

ENABLING SERVICES

National Goal 3: Percent of CSHCN with medical home

FY 2000 Goal: 85% with medical home
FY 98/99 Progress: 83% with medical home
Population: CSHCN

- Progress toward this performance objective is difficult to measure. Currently, there is no data source for determining the number of CSHCN with a primary care provider

(PCP) when they have private commercial insurance or are uninsured. For the purpose of this report, medical home equals primary care provider. In Oregon if a child is insured through the Oregon Health Plan, (Medicaid Managed Care) or a commercial managed insurance plan, they must have a PCP.

- Family education on the importance of a medical home was provided through CDRC tertiary clinics, CaCoon and Community Connections Network (CCN). Continuing education was provided to primary care physicians through CCN conferences and on-site consultation to individual CCN physicians.
- A curriculum was developed through the Community Consultants in the Care of CSHCN project and disseminated to physicians in CCN and to a broader audience of community-based health care providers.
- Initial discussions took place regarding the concept of the medical home.

State Goal 2: Percent of physical and/or sexual abuse against women

FY 2000 Goal: 10% of women report physical and/or sexual abuse
FY 97/98 Progress: est. 13.3% of women have experienced physical/sexual abuse
Population: Women

- The estimate for physical and/or sexual abuse is based on a telephone survey of 1,855 women aged 18 to 64. Physical abuse is defined as physical assault, sexual coercion, or injury by an intimate partner.
- OHD continued representation on the "Love Shouldn't Hurt Committee, a consortium of community organizations dedicated to the prevention of domestic violence through educational programs during National Domestic Violence Awareness Month.
- The Women's and Reproductive Health Manager at the OHD has been appointed to the Attorney General's Task Force on Sexual Assault.
- OHD provided leadership to the Oregon Health Systems In Collaboration (OHSIC) Domestic Violence Task Force. The Task Force is responsible for the development and implementation of employer response on Domestic Violence through leadership, patient, family, workforce, and community of the OHSIC membership.

- The Family Planning program added required assurances to recipients of program funds that teen clients be counseled on how to avoid coercive sexual relationships.
- The Women's Health Program Development Manager attended First National Sexual Violence Prevention Conference in Dallas, Texas in May. This conference was sponsored by the CDC and the Texas Association Against Sexual Assault (TAASA).
- OHD provided research leadership for the Oregon Governor's Council on Domestic Violence to develop and complete a 1998 Needs Assessment. This Needs Assessment report demonstrated that previously-relied upon measures of the prevalence of domestic violence may be seriously under-representing the problem, with conclusions that the prevalence of physical abuse through domestic violence in the state may be as high as 13.3%. The OHD is investigating the feasibility of conducting further analysis with the data collected from the Needs Assessment.
- The Women's and Reproductive Health Manager attended the CDC sponsored conference on violence and reproductive health in June 1999.
- The new state-wide WIC computer system has added mandatory IPV screening questions to their WIC certification and re-certification screen.
- The IPV Health Educator position was increased from a part-time position to a full-time position. A Women's Health Program Development Manager position was created and filled and part of that position will be to work on issues of IPV.
- As part of the MCH Block Grant Needs Assessment, Intimate Partner and Domestic Violence was identified as one of the five leading health issues in Oregon which need more intensive assessment and planning. Presently an five year plan is being created to address IPV and Domestic Violence.

State Goal 3: Percent of high risk infants in Babies First! meeting developmental standards at 12 month screening

FY 2000 Goal: 82% screened normal for development
FY 97/98 Progress: 79% screened normal for development
Population: Infants

- Data for 1999 is not yet available.
- 89% screened normal on motor screening as compared to 85% in 1995/96 and
- 70% screened normal on growth screening as compared to 68% in 1995/96
- The Babies First! Program provided nurse home visiting services in FY98-99 to 8,805 clients who received screening, education, counseling, case management, advocacy, and referral services.

POPULATION-BASED SERVICES

National Goal 4: Percent of newborns screened for phenylketonuria (PKU), hypothyroidism, galactosemia and hemoglobinopathies.

FY 2000 Goal: 100% newborns screened
CY 98 Progress: 100% newborns screened
Population: Infants

- Number of live births are not available yet for 1999. However, Oregon requires 100% newborns to be screened so progress on newborn screening will be maintained.
- Oregon Health Sciences University consultants began the process of updating the 1995 edition of the Newborn Screening Practitioner Manual to be distributed to hospitals, physicians and nurse midwives.
- A brochure was distributed to parents of newborns which explains the newborn screening program and why their child is being screened. The parent brochure was also available on the Oregon Health Division/ Public Health Laboratory website.
- Oregon continued to offer screening at no charge to parents who are unable to pay for it.
- Screening practice profiles were generated for all birthing hospitals. These profiles help improve the timeliness and accuracy of testing.

National Goal 5: Percent of children through age 2 completing age-appropriate immunizations

FY 2000 Goal: 78% of 19 to 35 months olds immunized
CY 98 Progress: 73% of 19 to 35 months olds immunized
Population: Infants, Children

- National Immunization Survey showed a 73.6% coverage level for Oregon children 19 through 35 months from July 1998 to June 1999.
- Of the 19,298 Babies First/Cacoon visits, 1,955 (10%) were to children betwee 24 and 25 months old. Of these 1,955 visits, 402 (21%) were screened for immunization completeness.
- The Oregon Partnership to Immunize Children (OPIC), Oregon's largest public/private partnership, developed an education campaign for providers, mailing the CDC's "Pink Book" to over 400 private providers in FY 98/99 and are repeating this project in FY 99/00 Furthermore, the Immunization Program mailed birth packets to new parents and have redesigned the packets to include more information for FY 00/01.
- A new Medicaid Interagency Agreement good through June 2001, was developed with increased matching funds for Immunization.
- Continued support and promotion of WIC and Immunization integration and other child/family health programs through the VISTA Health Links Project. This project employs VISTA Volunteers to work in LHDs on improving WIC/Imm integration, increasing access to perinatal care and maximizing outreach for the Oregon Health Plan.
- Vaccines for Children (VFC) enrollment of private provider sites who give immunizations was at 93%. The VFC program continued provider education on free VFC vaccine for eligible populations and the need for reasonable administration fees and office visit charges.
- Continued support and promotion of public/private partnerships between LHDs and private providers. County-wide meetings were held across the state to promote VFC and ALERT. These meetings provided an opportunity to assess county immunization

rates using ALERT data and encourage providers to submit data to ALERT in order to better assess rates. Plus an immunization coordinators' training conference was held in 1999.

- In 1999, Oregon Immunization ALERT had 94% of private clinics that give childhood immunization enrolled. Approximately 78% were sending in data on a regular basis. Ninety-six percent of Oregon's children ages 0-2 years old had immunization data recorded in ALERT. Moreover, ALERT was awarded an Outstanding Registry award from All Kids Count in May 2000 with high marks for fully operational status.
- Developed a statewide bilingual parent education campaign, cosponsored by OPIC, Oregon's public/private partnership. The campaign included press releases, media kits, radio spots newspaper ads and bookmarks reminding students and parents of the new school requirements for Kindergarten and 7th grade. A similar campaign will be repeated in August 2000.
- Assessments and Feedbacks using the AFIX model were completed for 34 LHDs, 5 private pediatric practices and 5 private adult practices. The strategy for assessing private sites changed in 1999 due to shrinking staff and resources. The new AFIX implementation plan for FY 00/01 focuses on two populations: i) one of the largest health plans in the Portland metropolitan area and ii) one of the priority counties in Southern Oregon who is found to have lower rates than the state average.
- Oregon Immunization ALERT has more than 5% duplicates, but given the high volume of data transmitted to ALERT, it is a normal condition of our registry to run about 10-15% duplicates. ALERT has automatic programs that take care of about 35% of the duplicates as they enter the registry, but much of the work is handled by a records specialist along with computer-aided programs.

National Goal 6: Rate of births per 1,000 among teens

FY 2000 Goal: 26 births per 1,000 among women aged 15-17 years
CY 1998 Progress: 26.4 births per 1,000 among women aged 15-17 years
Population: Children

- Oregon calculates teen pregnancy rates by totaling the number of births plus the number of induced abortions divided by the total number of teen females ages 10-17. Preliminary data indicate that our teen pregnancy rate for 1998 has decreased to 17.2 per 1,000 females 10-17 compared to 18.0 for 1997. Counties where the 5 year aggregate (94-98) teen pregnancy rate is significantly lower than the state rate (94-98 aggregate = 18.4) are: Baker, Benton, Clackamas, Curry, Deschutes, Grant, Jackson, Josephine, Polk, Tillamook, Union, Wallowa, and Washington.
- The Oregon Health Division in partnership with Adult and Family Services (AFS), Department of Human Resources is working with a variety of state and local agencies to develop and begin implementation of the six strategies included in the updated Governor's Oregon Adolescent Pregnancy Prevention Action Agenda 2000. These prevention strategies include:
  - – Supporting positive community values and norms
  - – Skills for life instruction
  - – Abstinence education
  - – Male involvement
  - – Contraceptive access
  - – Legal issues
- *Abstinence Only Program:* Oregon's abstinence-only program, STARS (Students Today Aren't Ready for Sex), continued growth in the 1998/99 school year by expanding to more, counties, school districts, and classrooms. STARS is in 32 of Oregons' 36 counties. This is an expansion of two more counties over the previous school year. STARS is in over half of the states 195 school districts. In the 1997/98 school year, 111 school districts were served, an increase of 11 school districts from the previous school year, and 28,007 6th and 7th grade students received the STARS

program. This is a small increase over the previous year despite the increase in number of schools participating. Many school districts made sure that all of their 7th graders received the program in the initial year of implementation, so that in the second year of implementation they only needed to deliver the program to their 6th grade classrooms. Since 1995 a total of 83,086 middle school students have received the program. By the end of the 1998/99 school year OHD trained 1,745 teen leaders to deliver the program. In order to meet the training need staff was increased to 6 training staff. Two of these positions are full time permanent positions with the remaining 4 being job rotation positions dedicated by other state agencies. In addition to providing training they maintain on-going technical support to ensure consistent, high quality delivery of the program.

- Teen Pregnancy Prevention Coordinator: During FY 99, the Teen Pregnancy Prevention (TPP) Coordinator in the Adolescent Health Section of CCFH continued intensive site visits around the state working with community TPP coalitions, planned activities and publications for teen pregnancy prevention month in May, and developed teen pregnancy prevention materials for local partners. A curriculum guide, Skills for Life and Sexuality Education, was developed in conjunction with numerous state and local partners. In addition, the Coordinator provided expertise and assistance in the planning of a teen pregnancy prevention statewide conferences including a Boys Summit focusing on male involvement issues.
- The Adolescent Pregnancy Prevention Coordinator served as co-chair of the State's Steering Committee of the Reduce Adolescent Pregnancy Project (RAPP). Members of the State Steering Committee have been incorporated into strategic planning work groups established for each of the six aforementioned state strategies.
- *Teen Pregnancy Rates:* The Governor's Oregon Adolescent Pregnancy Prevention Action Agenda 2000 six-part strategy is driving Oregon's adolescent pregnancy prevention activities. Our collective goal is through *all* of our programs to reduce

adolescent pregnancy. Due to the comprehensive nature of Oregon's approach, it will always be difficult to determine which specific strategy or part of the Action Agenda reduced teen pregnancy. However, during this period, Oregon saw a decline in the teen pregnancy rate.

National Goal 7: Percent of children receiving dental sealants to prevent tooth decay

FY 2000 Goal: 35% of third-grade children receiving dental sealants
FY 98/99 Progress: Not available; 27% in 1991-93
Population: Children

- According to the Oral Health Needs Assessment conducted in 1991-93, 27% of third-grade children had dental sealants in their first permanent molars.
- The Dental Health Project Coordinator supervised and coordinated school-based dental sealant programs in six counties. Multnomah and Jackson Counties sponsored programs, with Douglas County sponsoring two separate events in March and May of 2000. Clackamas, Hood River, Marion, and Tillamook were funded by the OHD from the Preventive Services Block Grant, which ended June 30, 1998.

National Goal 8: Rate of deaths to children under 14 per 100,000 children caused by motor vehicle crashes

FY 2000 Goal: 3.5 deaths per 100,000 children under 14
CY 98 Progress: 4.1 deaths per 100,000 children under 14
Population: Children

- Because motor vehicle crashes are the leading cause of unintentional death in children, the Child Injury Prevention Coordinator (CIPC) continues to promote inspection clinics on the correct use of car safety seats in the quarterly mailings to: 36 local health departments, 62 community hospitals, migrant health clinics, Indian Health Service and injury prevention programs that are partners of the eight Oregon Area Trauma Advisory Boards.
- The CIPC, along with interagency partners, promoted a statewide passenger safety awareness week to promote seat belt use and safety restraint use.
- The CIPC and collaborators, such as Fred Meyer, Alliance for Community Traffic Safety (ACTS) of Oregon, and Costco, restarted a safety seat voucher program for

low income families. The CIPC and ACTS of Oregon provided technical assistance to a safety belt and car seat coordinator in each local health department.

- The CIPC applied to the Oregon Department of Transportation to receive funding to expand the training for certified safety seat technicians at selected local health departments.

National Goal 9: Percent of mothers who breastfeed upon hospital discharge

FY 2000 Goal: 70% of mothers breastfeeding their infants
CY 98 Progress: 63.7% of mothers breastfeeding their infants
Population: Infants

- The Breastfeeding Promotion Committee continued innovative activities to improve breastfeeding rates in Oregon. A statewide survey of hospital breastfeeding practices was conducted, breastfeeding questions were asked on PRAMS, the Breastfeeding-Friendly Employer project was continued with new products developed including a Breastfeeding Welcome Here sticker, "Breastfed Babies Welcome Here" childcare packets were distributed statewide to childcare providers, and a statewide media event during World Breastfeeding Week was conducted. Local, national, and international media coverage of Oregon's innovative activities occurred.
- OHD supported the passage of Senate Bill 744 which affirms a women's right to breastfeed in public. Business cards stating the breastfeeding law were printed and distributed to hospitals and the public.
- OHD supported the Executive Order signed by the Governor stating that all state agencies must assure the breastfeeding women returning to work have a clean, private location and flexible break time to express breast milk. OHD is identified as the lead agency providing technical assistance in the implementation of the order.
- The WIC program continued to participate in the Loving Support campaign.
- Efforts to improve data quality from breastfeeding surveillance continued.

National Goal 10: Percent of newborns screened for hearing impairment

FY 2000 Goal: 15% of newborns screened
CY 98 Progress: 11.9 % of newborns screened
Population: Infants

- The Child Development and Rehabilitation Center, on behalf of the Oregon Health Division, convened a Newborn Hearing Screening Advisory Committee to examine the feasibility of implementing statewide newborn hearing screening in Oregon. The advisory committee consisted of four subcommittees on: a) procedure and technology, (b) costs and benefits, c) options to implement statewide, and d) legislative. The results of the study were compiled in a final report and provided to the Oregon Health Division in October 1998.
- Based on the Advisory Committee's final report, House Bill 3246 was drafted to mandate newborn hearing screening in hospitals and birthing centers with 100 or more births per year. The legislation is sponsored by a bipartisan group of legislators and several of the organizations that participated in the Advisory Committee.
- The Oregon legislature finally adopted a bill that mandated newborn hearing screening, beginning July 1, 2000, for all babies born in hospitals with more than 200 births per year. No provision was made for individual level data collection or tracking. Hospitals only need report to the Oregon Health Division on an annual basis the aggregate numbers of babies screened and babies not passing. The bill did mandate the creation of an Advisory Committee to assist the Oregon Health Division in making recommendations for improvements in the program to the next legislative session.
- The Oregon Health Division reconstituted a Newborn Hearing Screening Advisory Committee, chaired by a member from the Tucker-Maxon Oral School. The advisory committee includes: several audiologists; a physician specializing in ear, nose, and throat conditions; several parents or grandparents of a deaf child; a physician specializing in pediatrics; a physician specializing in neonatology; a representative of a hospital obstetrics department; two deaf adults; a representative of the Department of Education; a representative of the Oregon Health Plan; three representatives of early intervention programs; three representatives of the OHD; a representative of a health

insurance company; and other advocates. The Advisory Committee met for the first time in November 1999.

- The Oregon Health Division has asked the Advisory Committee to assist in the development of resources lists of available screening equipment and training protocols; criteria for identifying audiologists capable of providing out-patient screening and diagnostic testing services; materials for educating hospital administrators, parents and health care providers regarding the new law; and the drafting of administrative rules.
- The Oregon Health Division conducted a survey of licensed audiologists in October 1999 to determine the extent and distribution of expertise in the testing of newborns and infants for hearing status. This survey will serve as the basis for developing criteria for a list of diagnostic testing sites, which the Division is mandated to provide to all hospitals providing screening services.
- By the end of FY 98/99, 27% of Oregon's newborns were receiving hearing screening tests.

State Goal 1: Number of children under 18 who are abused or neglected

FY 2000 Goal: 11 children under 18 abused or neglected
CY 98 Progress: 13.5 children under 18 abused or neglected
Population: Children

- The percent of reports for which a field assessment was conducted has decreased from 61% in 1996 to 51% in 1999.
- The State Technical Assistance Team (STAT) provided data to the Office of Services to Children and Families (SCF) for the SCF annual report on child abuse and neglect. STAT provided technical assistance and data collection tools to county multi-disciplinary teams investigating cases of fatality,
- STAT team members attended conferences on child maltreatment and on child fatality review.
- STAT staffed three State Child Fatality Review Team meetings.
- STAT collected data from county teams on 1999 child deaths that include policy recommendations for prevention of morbidity and mortality due to abuse and neglect.

- STAT's research analyst revised the data collection tool used in the Child Fatality Review process.
- The number of reports has continued to increase in the past decade due to improved methods for documenting calls and public knowledge about mandated reporting.
- STAT's coordinator who is a child protective service worker has developed materials regarding mandatory reporting for new employee orientation at OHD.
- STAT team members developed a poster presentation at the Western Region Child Abuse Conference known as SCAR, on child fatalities in Oregon.
- The Center for Child and Family Health, through a needs assessment process, identified child abuse and neglect as a priority public health issue and is currently developing recommendations and strategies to guide the center's activities over the next five years.
- Public health nursing is a key stakeholder in The Early Childhood System of Services and Supports, representing the nursing role in developing a coordinated, comprehensive plan for children (0-8) and their families.

State Goal 4: Percent of children birth to 4 years caries free

FY 2000 Goal: 57% children birth to 4 years caries free
FY 97/98 Progress: Not available; 53% children birth to 4 years caries free in 1991-93
Population: Children

- According to the Oral Health Needs Assessment, conducted in 1991-1993, 53% of preschool children were caries free. No other data are available.
- The OHD provides technical assistance and training on caries prevention strategies for dental and non-dental providers.
- All LHDs received an educational video on the identification and prevention of Baby Bottle Tooth Decay.
- The OHD, as fiscal agent for the Early Childhood Cavities Prevention Coalition received a small grant from the Northwest Health Foundation to implement their provider education campaign. A packet of educational materials regarding early

childhood cavities and prevention strategies was designed and was distributed to 3,000 health care providers throughout the state.

State Goal 6 (5R): Percent of adolescents who report no tobacco

FY 2000 Goal: 85% of 8th graders reporting no tobacco use in past 30 days
CY 99 Progress: 84% of 8th graders reporting no tobacco use in past 30 days
Population: Children

- The 1998 Oregon Public School Drug Use Survey reported 20.4% of 8th graders smoked cigarettes during the last month (80% free of cigarette use). This is a small downward trend between 1996-98. Recent past use (30 days) of cigarettes was reported by 15% of 8th graders (85% free of cigarette use within the past 30 days) as measured by the *1999 Youth Risk Behavior Survey (Middle School Version)*. However, additional youth may be involved with other forms of tobacco (smokeless, cigars).
- The OHD established a Tobacco Prevention Program in the Center for Disease Prevention and Epidemiology. One of the program's strategies include grants to LHDs and schools for comprehensive tobacco prevention activities. A total of 23 tobacco grant projects involving 56 school districts have been distributed to schools statewide as of 2000. All 36 counties are funded for community tobacco prevention activities. Six multicultural organizations and nine tribal efforts are underway to target efforts to reduce disparities. Three additional efforts to reduce health disparities are planned for FY2000-2001.
- Resources are limited in CCFH to work directly and exclusively on tobacco, alcohol, and other drug prevention programs for the 8th grade population.
- The CCFH School-Based Health Center (SBHCs) Program (44 total centers of which 8 are in middle schools) provided tobacco, alcohol, and other drug use education, individual screening, or assessments and referral for treatment when students presented with or were identified with these risk factors. Several centers have specifically piloted tobacco cessation programs at SBHCs.

State Goal 7: Percent of pregnancies among women 15-44 that are unintended

FY 2000 Goal: 43% unintended pregnancies
CY 98 Progress: 52.8% unintended pregnancies
Population: Women

- Data notes – numerator: estimate of unintended births based on PRAMS survey data for 12 months beginning Summer 1998, plus number of induced abortions reported for 1998. Denominator: number of live births plus induced abortions for CY 1998. OHD began developing capacity to monitor unintended pregnancy rates through the Pregnancy Risk Assessment Monitoring System (PRAMS) survey in November, 1998. The full year's data should be available for reporting FY 99 progress.
- Client data for Calendar Year 98 show that OHD's Family Planning Program served 52,004 clients, preventing an estimated 13,366 unintended pregnancies.
- Program improvements during FY 98 included developing additional staff capacity for local agency training coordination and support; improvement in electronic access to information for local agencies and evaluation of teen service components of local agency programs.
- Ongoing activities included program evaluations of 12 local agency programs; the provision of technical assistance and on-site staff training for programs, coordination of contraceptive supply availability through contracted central purchasing and through coordination with the state STD program.
- A major program expansion initiative was launched with the approval and initial implementation of a HCFA 1115 waiver providing coverage for family planning services for Oregonians whose family incomes fall between 100-185% of the federal poverty limit (100% of poverty limit and below are currently covered by the Oregon Health Plan). Implementation of this program among clinic sites receiving grants from OHD resulted in a drop in the proportion of clients required to spend out of pocket funds in order to receive contraceptive services from 42% of clients to 11% of clients.

INFRASTRUCTURE BUILDING SERVICES

National Goal 11: Percent of CSHCN with source of insurance for primary and

specialty care

FY 2000 Goal: 95% children with insurance source
FY 98/99 Progress: 96.4% children with insurance source
Population: CSHCN

- The performance indicator for FY 98/99 includes children with OSCSHN funding as their primary or secondary insurance source. Therefore, the percent of children with insurance is greater than the state average of 90%.
- The OSCSHN program referred all potentially eligible children to the Oregon Health Plan (OHP), Children's Health Insurance Program (CHIP), Family Health Insurance Assistance Program (FHIAP) and SSI.
- The OSCSHN financial counselors provided follow-up on referrals to OHP, CHIP, FHIAP, SSI to assure that families received the benefits if eligible and to enroll children in the OSCSHN program if denied other coverage.
- The OSCSHN program continued to function as an insurer for the uninsured and provided a safety net for the underinsured children.

National Goal 12: Percent of children without health insurance

FY 2000 Goal: 9.5% children without health insurance
FY 98/99 Progress: 9.6% children without health insurance
Population: Children

- The Oregon Health Plan has made it possible for thousands of women and children to access medical care since the state was granted a waiver for the use of Medicaid funds. Oregon has developed an OHP application that serves as the channel for both OHP and CHIP, assigning children first to OHP and secondly to CHIP depending on income level and state funds available to support these insurance programs. While clients express satisfaction with their medical benefits and care once on OHP, there are emerging barriers to getting on OHP that are being documented for state review. This includes a cumbersome, multi-page application and eligibility documentation requirements, lack of outreach staff to assist clients with completing the application, misinformation or lack of awareness about the availability of OHP and other issues.
- Oregon's CHIP, implemented in July 1998, is a Medicaid look-alike program which provides the exact same benefits as the Oregon Health Plan. To date, the program has nearly reached its goal of 17,000 children enrolled in CHIP. Currently, state funding is allocated to serve 17,000 low income children. In January 1999, the Oregon Health Division was awarded a three-year $1 million Covering Kids Initiative grant by the Robert Wood Johnson Foundation to develop an outreach program to enroll low income children in a health coverage plan. The Oregon initiative includes three pilot projects in diverse parts of the state to outreach and enroll: 1) Latino children in Southern Oregon; 2) rural school children in Eastern Oregon; and 3) homeless youth and kids in schools in the Portland metropolitan area. The initiative also includes a small media campaign targeting specific racial/ethnic groups who are traditionally underserved populations. A State Agency Council on Coordination was established by the grant to look at the specific goals of OHP enrollment simplification and interagency service coordination.

- FHIAP, created in 1997, has provided subsidies for approximately 1,443 children out of 3,900 individuals served. FHIAP's target goal is 7,500 families earning 170% or less of federal poverty guidelines. When employer-based coverage is involved, the employer must pay a minimum level of the employee's cost. If the family is purchasing the coverage on their own, FHIAP pays a portion of the monthly premium. During 1999, FHIAP set a target goal of 500 enrollees a month to address it's current backlog of approximately 25,000 families on the waiting list. The projected wait period for those signing up is nine to twelve months.

National Goal 13: Percent of Medicaid-eligible children receiving a service paid for by the Medicaid Program

FY 2000 Goal: 92% of Medicaid-eligible children receiving a service
CY 98 Progress: 87.7% of Medicaid-eligible children receiving a service
Population: Children

- Notes on the CY 1998 data: 1998 numerator: The number of children receiving services paid by Medicaid is not available. The number, 254,615, is a count of the number of children enrolled in Medicaid at any time during the calendar year. 1998 denominator: The estimate is the number of children aged 0-18 who are at 170% of poverty, an imputation based on population estimates for 150% and 200% of poverty. The number of children enrolled in Medicaid who received a service paid by Medicaid is not current available. Health Division database planning includes adding and maintaining Medicaid and CHIP data tables.
- Many of the children were only enrolled for a short time during the year while others maintained enrollment throughout the year.
- Employer-based health coverage accounts for 82% of all coverage for children in the state, while public sources make up to 13% and the remaining 5 percent is from other sources.
- The VISTA Health Links Project provided 13 VISTAs in 10 of Oregon's 36 counties to link women and children to the appropriate services. VISTA workers provided

clients assistance and information on the Oregon Health Plan (Medicaid), immunizations, prenatal care, WIC, and other health issues/concerns.

- SafeNet, the MCH hotline, provided services to link low income Oregonians with health care services within their communities, including information on the Oregon Health Plan.
- The Oregon Health Plan has contracts with 32 of the 34 local health departments. As outreach facilities, these local health departments can distribute and date stamp the OHP applications.

National Goal 14: Degree to the state assures which family participation in program and policy activities in the State CSHCN program

FY 2000 Goal: Score of 10 out of 18
FY 98/99 Progress: Score of 8 out of 18
Population: CHSCN

- Family members participated in and presented at training activities.
- Families, including Family Voices coordinators, participated in task forces, planning and evaluation activities addressing service systems and quality of care.
- Twenty-two parents representing 11 Hispanic families participated in evaluating care coordination and services in a culturally sensitive model developed through the Community Action and Outreach for Children who are Hispanic (COACH) project.
- Families participated in the OSCSHN planning process to follow-up on findings of the joint CDRC/Medicaid needs assessment.
- CDRC supported family participation in OSCSHN activities and reimbursed for associated costs, for example, child care and transportation.
- Family Voices and CDRC partnered to gain information on needs and issues of families whose children have special needs.
- Family Voices, CaCoon and Community Connections worked together to share meaningful information about managed care and getting needed services for CSHCN.

National Goal 15: Percent of very low birth weight births

FY 2000 Goal: 1% of very low birth weight births
CY 98 Progress: .9% of very low birth weight births
Population: Infants, pregnant women

- Oregon had 45,228 births in CY 1998, which included 2,434 infants with a birth weight under 2,500 grams (LBW) (5.4%) and 407 infants under 1,500 grams (VLBW) (0.94%). The VLBW rate was maintained below the national benchmark with marked disparities among certain groups (African Americans and in certain rural areas).
- The Perinatal Program used outreach (initial needs assessments) and public health nurse case management/home visiting. Services were provided through the Maternity Case Management (MCM) program, specifically targeting women at risk for low birth weight infants and placing emphasis on education about premature labor.
- A Fetal and Infant Mortality Review (FIMR) project was implemented in Jackson county which is a tertiary care center for southern Oregon and northern California. This review panel and advisory group is identifying potential contributing factors related to poor birth outcomes and other perinatal care delivery system gaps and is implementing recommendations for community changes and improvements. Other counties have community-based projects that address the prevention of low birth weight as well as the needs of low birth weight infants and their families.
- Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) postpartum survey completed the first year and continued for a second year with some changes in the questionnaire. This project will assist in developing programs and policies related to the prevention of low birthweight.
- Support and technical assistance were provided to programs that provided pregnancy prevention services to reduce the number of unintended and unplanned pregnancies to women and teens at risk for premature birth (teen pregnancy prevention and family planning).

National Goal 16: Rate per 100,000 suicide deaths among adolescents

FY 2000 Goal: 9 suicide deaths per 100,000 among age 15-19

FY 98 Progress: 6.7 suicide deaths per 100,000 among age 15-19
Population: Children

- In 1998, Oregon's suicide rate was 17.4 per 100,000 population, compared to 16.7 in 1997. Previously, the highest rate was 17.0 suicides per 100,000 population in 1994.
- In June 1999, the Youth Suicide Prevention Coordinator (YSPC) completed a literature review and research necessary to begin writing the state plan for youth suicide prevention. This plan will include 15 strategies for the prevention of youth suicide that are crafted to focus on local intervention efforts. It is anticipated that the state plan will be published in July of 2000.
- The YSPC presented at the Springfield Child Abuse Regional Conference in October of 1998. Over 500 law enforcement, child protective services workers, and district attorneys attended this presentation.
- The YSPC sat on the conference planning committee for the Summer Violence Institute in the fall of 1998. A presentation was planned for the Institute scheduled for July of 1999.
- The YSPC worked with the American Foundation for Suicide Prevention, Northwest chapter (AFSP NW) to coordinate a survivor's conference attended by 80 community members at the Division in November of 98.
- The YSPC and the Injury Prevention and Epidemiology Manager attended the Western Region EMSC conference on Youth Suicide in Reno, NV in September of 1999.
- The YSPC and the Injury Prevention and Epidemiology Manager attended a meeting in April of 1999, in Seattle hosted by Region X and Region IX to collaborate on an proposal to SAMHSA to create a conference addressing suicide risk and the needs of youth with dual diagnosis.
- During the spring and summer of 1999 the YSPC collaborated with Dr. Gary McConahay of Josephine County Mental Health to develop a proposal to Northwest

Health Foundation to fund a gatekeeper program which would train 1000 gatekeepers in a nine county area.

- In December of 1998 the YSPC was invited to attend a Native American gathering to address 250 youth at Ka-Ne-Ta on youth suicide issues.
- The YSPC worked with AFSP NW to develop a committee to replicate the Washington State model for suicide prevention work through the state PTA. This group plans to present at the Summer Violence Institute in July of 2000.
- The State Child Fatality Review (CFR) Team and local CFR teams continued reviewing youth suicide deaths and reported on those reviews to the Division's State Technical Assistance Team (STAT).
- STAT published the second Child Fatality Review report in December 1999, which contained a section on youth suicide. The local and state team recommendations for prevention included: need for focus on at-risk youth, need for healthcare providers to assess firearm access in homes of suicidal youth, need for more thorough investigation of suicide, need for more complete efforts to address postvention after a suicide, safe storage of firearms and adequate screening and referral as a way to identify at risk youth for prevention efforts.

National Goal 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries

FY 2000 Goal: 90% born at facilities for high-risk deliveries
CY 98 Progress: 79.9% born at facilities for high-risk deliveries
Population: Infants, pregnant women

- Oregon does not have a state categorization of Level II and III NICUs and other specialty and sub-specialty perinatal services. The OHD has been creating descriptions of the perinatal services provided at each hospital and learning the criteria by which transfers are determined, as well as the current trends and patterns of those transfers.
- Although there are 56 hospitals in the state that provide obstetric care, most VLBW babies are born at 6 regional facilities. Preliminary findings indicate a lack of formal systems for transfers.

- OHD has been exploring ways to develop Level II and III categorization and to assist facilities, providers, and emergency medical services to formalize protocols and agreements addressing perinatal care and transfers.

National Goal 18: Percent of infants born to women receiving prenatal care beginning in the first trimester

FY 2000 Goal: 83% infants born to women receiving early prenatal care
CY 98 Progress: 79.9% infants born to women receiving early prenatal care
Population: Pregnant women

- *Oregon MothersCare* (OMC), a statewide initiative to improve access to early prenatal care, was launched through three county health departments and two community based agencies as a result of a federal March of Dimes grant. Another site at a county health department implemented the OMC program with the aid of a Healthy Start grant. This program is developing a partnership among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a toll-free hotline, a referral and support system to provide women assistance in finding and using prenatal services in their community, and an ongoing public awareness, outreach, and education campaign.
- In addition, several counties have developed model "one-stop shopping systems, providing women with pregnancy testing and assistance in getting Oregon Health Plan, WIC, and initial prenatal care services.
- The Oregon Health Plan eligibility for pregnant women remains at 170% of Federal Poverty Level.
- OHD collaborated with OMAP and the Conference of Local Health Officials (CLHO) on the expansion of the Community-Based Application Assistance project to the OHP Outreach Facility program. This program provides assistance in applying for the Oregon Health Plan (Medicaid) for individuals and their families at health departments, school-based health centers, and other sites. The program includes most of the 34 county health departments and many other community based sites throughout the state.

- The VISTA HealthLinks project includes a component of improving access to prenatal care and outreach to pregnant women as a focus for VISTA workers placed in 20 local health departments around the state.
- A collaborative effort between OHD and OMAP facilitated a multi-agency, public and private, review and revision of Maternity Case Management (MCM) throughout the state to improve the quality and consistency of this service. OHD continued to provide funding and technical assistance to local health departments to support Maternity Case Management and home visiting services to increase access to and effective utilization of prenatal care and other services.
- OHD provided funding and technical assistance to local health departments to provide prenatal care to 2,166 women without public or private insurance.

State Goal 5: Percent of low-income children aged one to four years with iron deficiency

FY 2000Goal: 16% children with iron deficiency
FY 98 Progress: 12.3% children with iron deficiency
Population: Children

- Data estimates are based on CDC Pediatric Nutrition Surveillance System, children aged 1 through 4 years.
- OHD staff participated in Quarterly Networking Meetings with public health nutritionists from Oregon State Extension Program, WIC, Oregon Dairy Council, Oregon Food Bank, and the Oregon Department of Education, Child Nutrition Program to develop child nutrition strategies within private and public entities who serve food to children of all incomes.
- OHD staff developed and delivered on-going nutrition education in- services for community nurses.
- OHD nutrition staff address community-wide pediatric iron deficiency anemia with local health agencies when providing the nutrition quality assurance review.
- Nutrition staff assisted in the planning of the new WIC data system, TWIST, which will provide accurate nutrition education information, appropriate client referrals, and allow efficient use of time while seeing WIC participants.

- OHD staff developed low-literacy nutrition education materials for use in public health clinics and school-based health centers on healthy eating and food disorders.

State Goal 8: Percent of CSHCN receiving care coordination services

FY 2000 Goal: 25% CSHCN receiving care coordination services
FY 98/99 Progress: 23% CSHCN received care coordination services
Population: CSHCN

- The data source used to calculate the FY 98 report is unknown. Therefore, progress toward the annual performance objective is less than projected, and the performance goal for 2000 has been changed. Measurements for FY 99 are based on the number of children receiving care coordination services through the State CSHCN programs.
- During FY 99, 1467 children and families received 6564 care coordination services through the CaCoon program. This is an 8.5% decrease since FY 98. CaCoon has been unable to keep up with the individual counties' salary increases for the public health nurses. Some county health departments have reduced the amount of time the nurses spend with CSHCN. Others have placed limitations on the number of visits per child and restricted program eligibility to preschoolers or children covered by Medicaid so that the county can bill for Targeted Case Management funding. This means that the program is unable to fully meet all the needs of all the children in a community needing service.
- Care coordination services were also provided by nurses and social workers at the CDRC tertiary level clinics and through CaCoon nurses who participate in the Community Connections Network clinics.
- Care coordination services were provided to 32 Hispanic families who have CSHCN as part of the Community Outreach Action for Children who are Hispanic (COACH) project in Marion County.
- CDRC and the Oregon Medicaid Office completed a joint conference entitled *Partnerships in Care.* Seventy-eight CaCoon nurses, Oregon Health Plan Exceptional Needs Care Coordinators and other individuals providing case management attended.

The goal of the conference was to provide information about CSHCN and to enhance collaboration among the care coordinators who work with this population.

- The planning process for a Fall 1999 CaCoon conference on the care of the extreme premature infant was begun. Partners included the Oregon Commission of Children and Families that administers the paraprofessional home visiting program Healthy Start and the Oregon Health Division that administers Babies First!, a high risk infant screening and tracking program. This collaboration furthered the efforts in the state to coordinate programs that provide care coordination services through home visitations.

State Goal 9: Percent of providers participating in continuing education addressing CSHCN

FY 2000 Goal: 5% providers participating in education experience
FY 98/99 Progress: 2.9% providers participated in education experience
Population: CSHCN

- CaCoon, CCN, the COACH project, and other CDRC provided workshops and inservices to community physicians, public health nurses, educators and other providers. These conferences have been well attended and rated highly by the attendees. CME and CEU credits were offered for the CaCoon and CCN conferences.
- CCN held their annual conference training 45 community physicians, nurses, educators, psychologists, social workers, physical therapists, speech pathologists, and other providers. CCN broadcast via Ed-Net to 12 sites on Assistive Technology reaching approximately 60 professionals. For the 14 physicians involved in CCN clinics, the clinics themselves served as training experiences. In addition, consultation and mentoring from CDRC/OHSU faculty were provided to each clinic site twice a year.
- COACH sponsored, through its technical assistance help from MCHB, a two day visit by John Evans, an expert in cultural competency from Texas. He spoke with community leaders, met with several different groups at CDRC and presented to a large group of OHSU faculty and community members. Through efforts of this grant-supported project, a newsletter, *The Vine,* is published. The purpose of *The Vine* is to

educate CaCoon, CCN, and CDRC staff, and the community about cultural competency issues.

- CaCoon offered a variety of training opportunities to CaCoon nurses, school and hospital-based nurses, early intervention staff, and other providers who work with CSHCN including: NCAST training to 31 nurses, a regional conference on pediatric cardiology for 22, and site visits twice a year to each county for 80 encounters.
- Robert Nickel, M.D., Assistant Director for Clinical Programs at the Eugene CDRC office, provided training to EI/ECSE, CaCoon and school nurses as well as medical and therapy staff at two sites in rural Oregon. Thirty-five local pediatricians attended one of the training sessions on latex allergies in children with Spina Bifida. In addition, Dr. Nickel, an occupational therapist and a physical therapist went monthly to one clinic site to collaborate with and train community health and education providers about management issues related to CSHCN.
- CDRC collaborated with the Medicaid Office on a training, *Partnerships in Care*: Resources for Children with Special Health Needs. Seventy-eight Oregon Health Plan care coordinators, CaCoon nurses and other providers attended.

State Goal 10: Percent of programs and providers with collaborative agreements for CSHCN services

FY 2000 Goal: 100% programs and providers with agreements
FY 98/99 Progress: 100% programs and providers with agreements
Population: CSHCN

- OSCSHN continued to renew and monitor interagency agreements and collaborate with numerous agencies to facilitate partnerships, coordinate care and outreach for eligible children.
- OSCSHN decided to discontinue this goal because an interagency agreement or contract is not a true measurement of coordination and collaboration between/among agencies and providers.

2.5 Progress on Outcome Measures

See Form 12.

Oregon has adequately met its goals for the national Core and the Negotiated state performance measures. In Oregon, the mortality rates represented by the six Core Outcome Measures have not significantly changed over a five year period. Comparing the performance measure results with the outcome measure results shows improvement, or at least maintenance of, health status across the Title V populations.

III. REQUIREMENTS FOR APPLICATION (Section 505)

3.1.1. Needs Assessment of the Maternal and Child Health Population

The Title V Agency initiated a process for needs assessment and planning which included the perceptions and expertise of individuals and professionals and addressing those issues with science-based programming and evaluation.

3.1.1 Needs Assessment Process

Overall Process

A Needs Assessment Steering Committee was established in late 1998 to lead the process. The members were comprised of program managers from the Health Division, the Child Development and Rehabilitation Center, and from a county health department. The Committee established that the assessment would be broader than the intent of the Title V requirements and would provide a foundation for program planning for any state or local program or service serving children and families. The goals for the assessment were:

- *Assess the health status of women, children, children with special health care needs, and families in Oregon*
- *Identify assets, best practices, and gaps within current systems of care*
- *Produce a working document to be used for program planning by a variety of providers*
- *Collect information needed to build a surveillance system to monitor the health status of women, children, children with special needs, and families*

The Committee adapted a tool from a community planning model developed under contract with the Maternal and Child Health Bureau at the University of North Carolina School of Public Health, under the direction of Mary Peoples-Sheps, PhD. This tool, "Self-Instructional Manual for Community Needs Assessment and Program Planning"[1]

[1]Peoples-Shep, M.D., Farel, A., Rogers, M.M. (1996) Program Planning and Monitoring: Self-Instruction Manual. Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services. No. MCU-37D501.

provided methods for prioritizing health issues and health problems, researching and designing appropriate interventions, selecting indicators, and deciding on a plan. Since the guide was geared toward a community-based setting, the Steering Committee adapted the tool to address issues and determine priorities on a statewide basis. The following steps were developed to complete the assessment are:

Step 1. Select priority health problems

Step 2. Conduct needs assessment for priority health problems

Step 3. Select best practices, interventions, and health status indicators

Step 4. Develop goals and objectives for Five Year Plan

The Oregon Title V Agency was able to complete Steps 1-3 for a statewide assessment of priority issues. Further community input in the Fall, 2000, will acheive Step 4.

Identifying Priority Issues: A simple survey was developed to determine the statewide priorities on 30 health problems affected the maternal and child health population Appendix B. The survey was sent to approximately 1,000 persons associated with health programs and services for women, children and infants. Almost 400 responses were returned. Out of thirty health issues, fifteen issues fell consistently within a variety of analyses. From these fifteen issues, the Title V Agency selected five leading health issues for assessment and planning:

- *Oral health of children*
- *Adequate prenatal care for all women*
- *Prevention of child abuse and neglect*
- *Adolescent mental health status and substance use prevention*
- *Intimate partner and domestic violence prevention*

The statewide survey was the first phase of prioritizing issues. The second phase required further prioritization within each issue to focus the assessment on the most urgent needs of the Title V stakeholders.

Collecting community input: The Title V Agency held five regional meetings in Fall 1999 with county health department nurses, staff and their key partners. The groups conducted brainstorms about the barriers and solutions that would help prevent and reduce risk factors leading to the five health problems and promote protective factors to reduce the impact of the health problems. The results of these brainstorming sessions formed the direction for research of the scientific literature, key indicators, and selecting effective interventions and successful strategies. This research comprised both Step 2 and Step 3 of our assessment.

Conducting the assessment: Step 2, conducting the needs assessment, incorporated a variety of activities. With the help of graduate students and Health Division staff, the key indicators, overall priority needs, and strategies, were collected using the following methods.

- *Interviewing people* - collecting qualitative information to drive research and policies based on stakeholder's observations, knowledge, and experiences
- *Researching issues* - reviewing professional literature (studies, surveys, evaluations) to identify effective interventions, standard practice, and strategies
- *Validating problems* - analyzing qualitative and quantitative data to determine disparities associated with the issues
- *Identifying needs and gaps* - analyzing the current system of services and recommending strategies for meeting population needs and service gaps

3.1.2 Needs Assessment Content

The needs assessment resulted in a variety of needs and gaps specific to the five issues. Common themes within all five issues were identified and became the foundation of the overall structure for the assessment. The overriding needs are:

- **ACCESS** - to insurance and appropriate services
- **EDUCATION** - for providers, parents, caregivers, and youth
- **DATA** - for more thorough knowledge and understanding of health status

The needs assessment, therefore, identified five health issues and three assessed needs. The issues fit into the Title V framework of population groups as follows:

Title V Population	***Oregon's Priority Health Issues***
Pregnant Women and Women	Prenatal care, intimate partner violence
Infants	Prenatal care, child abuse and neglect
Children	Oral health, child abuse and neglect, adolescent mental health/ substance use
Children with special health care needs	Oral health, prenatal care, child abuse and neglect, adolescent mental health/ substance use

The needs for all the issues fit into the Title V framework pyramid of services.

Title V Pyramid of Services	***Oregon's Assessed Needs for Priority Issues***
Direct Services	Access
Enabling Services	Access, Education
Population-Based Services	Access, Education
Infrastructure Services	Access, Education, Data

The assessment content includes current status of the health problems and recommendations and strategies for public health to meet the needs of access, education and data for each of the five health issues. The Title V Agency chose to present the

identified needs for improving health in the form of recommendations for use in program planning. Strategies and key indicators related to these recommendations are presented to provide ideas for action and measuring results of actions. The Executive Summary, Appendix B is being distributed widely to promote public health action at the state and local levels. The full assessment documents will be distributed among state and local level maternal and child health program leaders to promote implementation of core public health functions to address all five issues.

The assessment resulted in cross-cutting public health recommendations crucial to improving the status of all five health issues and the child and family population: child oral health, prenatal care, child abuse and neglect, adolescent health and well-being, and intimate partner violence.

OVERALL RECOMMENDATIONS FOR PUBLIC HEALTH IMPROVEMENT:

Increase and improve:

- Health insurance coverage for children, including children with special health care needs, adolescents, and pregnant women
- Health care provider visits for Oregon Health Plan eligible clients
- Dental care for young children, including children with special health care needs, and in rural areas
- Universal quality prenatal care
- Mental health services access for youth and parents
- Substance use treatment access for youth and parents
- Nurse home visiting for high risk families
- Health and caregiver knowledge of screening for abuse and substance use
- Education in positive parenting skills

- Data collection and analysis for continuous monitoring of all issues

Strategies for achieving the recommendations were collected during the assessment process through discussions with community leaders, key informants, and from researched literature. Again, there were cross-cutting public health strategies that provide ideas for action at the state and local levels. The strategies will be used for program planning, coordination, collaboration, and evaluation.

OVERALL STRATEGIES FOR MEETING NEEDS:

Advocacy - by public health leadership to create policies to increase access and services

Partnerships- between public, private and non-profit agencies to collaboratively implement strategies and meet objectives

Outreach - for families eligible to use services and programs

Training - for health providers and caregivers to screen and refer for specific health risk and protective factors

Education - to help parents, youth and children practice healthy behaviors

Data utilization - to continually assess health status and disparities

Next Steps: The Center for Child and Family Health and the Child Development and Rehabilitation Center will continue to build on the foundations of this needs assessment. To identify geographic and demographic disparities in Oregon within the five issues, a community assessment tool will be developed for county health departments to assess priorities and needs. The county level assessment will provide the state Title V Agency with more information to allocate resources to more effectively meet needs and reduce disparities.

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The five priority issues cut across all the Title V population groups, the Overview is presented under headings of the Oregon needs assessment, with reference to the most relevant population. An overview of children with special health care needs is also included.

Oral Health for Children
Title V Population: Infants, Children 1-21, CSHCN

1. Community Concerns
    - Communities need dentists who accept children insured by the Oregon Health Plan
    - Parents and caregivers need to know more about preventing tooth decay
2. Data Facts
    - According to the Centers for Diseases Control and Prevention, by age 2, only 25% of children had ever visited a dentist; by ages 5 and 7, the proportions increased to 75% and 89% respectively.
    - The Healthy People 2010 goal is to reduce dental caries so that the proportion of children who have had one or more cavities is no more than 15% among children aged 2-4, 40% among children 6-8, and 55% among adolescents aged 15.
    - 47 % of children aged 3-5 years old report a history of dental caries; 55 % of children 6-8 have a history of dental caries (1992-93 Oral Needs Assessment.)
    - Early childhood caries, frequently referred to as baby bottle tooth decay, can be a devastating condition often resulting in hospital visits for treatment with costs of $1,500 to $7,000.
    - Oregon is 45th in the nation for providing community water fluoridation. The Oregon Health Division Drinking Water Section reports that 24% people in Oregon communities have community water fluoridation systems, and 2% of Oregon communities have naturally occurring fluoride. The Healthy People 2010

goal is 75% of people in communities served with optimally fluoridated water, from a baseline of 62 % in 1992.

- 43% of students in 243 schools (Head Start to 8th grade) were enrolled in the King Fluoride program in 1997-98.
- It is unknown how many Oregon children have received dental sealants. The Healthy People 2010 goal is 70% of children between 8 and 14 who have received protective sealants. (1988-1994, 23% of 8-year-olds and 24% of 14-year-olds received sealants in permanent molar teeth.)
- 45% of parents do not provide their children 18 and younger with preventive oral health. (HP 2000, 98-99 Review)

Prenatal Care
Title V Population: Women and Pregnant Women, Infants

1. Community Concerns
    - Quick entry into prenatal care for all women
    - Comprehensive services, such as case management, substance use treatment, for pregnant women
    - Adequate funding for prenatal care for all pregnant women
    2. Data Facts
    - In 1997, eight Oregon counties reported that more than 25% of pregnant women smoked.
    - 81.1% of all women received first trimester prenatal care in 1997; however, at-risk groups are well below that level.
    - Women <u>without</u> first trimester prenatal care, according to 1998 birth certificate data:
        - 32% of unmarried women
        - 33% of Native American women

  - 34% of Hispanic women
  - 35% of teens under the age of 20
  - 35% of women without private insurance
  - 41% of women with less than a high school diploma

- 8.3% of women who smoked had infants born with a LBW and 7.3% of women who consumed alcohol had a LBW infant
- 11.2% of babies born to African American women were low birth weight in 1998.
- Oregon's low birth weight rate has fluctuated only slightly from about 5.6 per 100 births in 1975 to 5.2 per 100 births in 1997.

Prevention of Child Abuse and Neglect
Title V Population: Infants, Children 1-21, CSHCN

1. Community Concerns
   - Lack of access and availability of a consistent health care provider for children
   - Inadequate access to drug treatment programs for parents with addictions
   - Lack of adequate and healthy child care and respite care
   - Limitations of Child Protective Services and Community Safety Net guidelines
   - Heavy caseloads in nurse home visititation programs such as Babies First! and CaCoon
2. Data Facts
   - In 1998, State child protective services (CPS) agencies reported to National Child Abuse and Neglect Data System (NCANDS) that: just over 900,000 children were the victims of substantiated or indicated child abuse and neglect in1998. State CPS agencies investigated an estimated 2 million reports alleging the maltreatment of almost 3 million children.
   - In Oregon, in 1999 there were 11,241 child abuse and neglect victims, a 10.8 percent increase from the previous year.

- Oregon ranks second highest in the nation in the rate of child maltreatment fatalities.

Adolescent mental health status and substance use prevention
Title V Population: Children 1-21, CSHCN

1. Community Concerns
    - Tobacco, alcohol, and illicit drug use
    - Mental health issues such as depression, stress, suicidal thoughts
2. Data Facts

    From the Oregon Youth Risk Behavior Survey 1999 (9th-12th grade)

    - 16% seriously considered suicide in the prior 12 months
    - 6% attempted suicide in prior 12 months
    - 44% had at least one drink of alcohol in past 30 days
    - 30% had five of more drinks of alcohol in a row in past 30 days
    - 4% report drinking alcohol on school property
    - 26% of sexually active youth drank alcohol or used drugs before their last sexual intercourse
    - 25% report smoking cigarettes in past 30 days
    - 43% of smokers began smoking at age 12 or younger

    Oregon Adolescent Health Information

    - Between 2,000- 3,000 Oregon students are treated for injuries resulting from suicide attempts each year (Oregon Health Division, 1995)
    - Approximately one in four 11^{th} grade students report using one or more illicit substances (excluding alcohol and tobacco) 30 days prior to the 1998 Oregon Student Drug Use Survey (OADAP).

- The 1998 Student Drug Use Survey shows that 43 percent of eleventh graders, 26 percent of eight graders, and 8 percent of sixth grade students reported drinking in the past 30 days
- The 1995 Oregon Household Survey indicates that more than 1 of every 5 (21.2%) Oregonians aged 18-24 have an alcohol abuse or dependency problem
- The Oregon Department of Education's Report on Dropout Rates in Oregon High Schools 1997-1998 indicate school staff cited substance abuse as the factor affecting 820 student's decision to drop out
- In 1997, in Oregon, 18 teen drivers between the ages of 15 and 19 died in alcohol related accidents
- Mental health diagnoses were made (regardless of provider type) in 18% of all visits to SBHC in 1998-1999
- A reported 40 % of homeless teenage males and 33% homeless teenage females in Oregon engage in injection drug use.

Preventing intimate partner violence
Title V Population: Women, Pregnant Women

1. Community Concerns
    - Inadequate capacity in the health care system to respond to intimate partner violence
    - Local programs feel unable to provide adequate safety plans and resources to clients who are victims
2. Data Facts
    - It is estimated that more than 1 of every 8 (13% or 123,000) Oregon women 18 to 64 years of age are estimated to have been victims of physical abuse by an intimate partner during the past year, according to 1998 Oregon Domestic Violence Needs Assessment

- More than 1 of every 6 (15% or 123, 400) Oregon children under 18 years of age are estimated to have witnessed the physical abuse of their mothers or caregivers during the past year.
- By the most conservative estimate, each year 1 million women suffer nonfatal violence by an intimate.
- Four million American women experience a serious assault by an intimate partner during an average 12-month period.
- Nearly 1 in 3 adult women experience at least one physical assault by a partner during adulthood.
- 28% of all annual violence against women is perpetrated by intimates.
- During 1994, 21% of all violent victimizations against women were committed by an intimate, but only 4% of violent victimizations against men were committed by an intimate.
- In 1993, approximately 575,000 men were arrested for committing violence against women. approximately 49,000 women were arrested for committing violence against men.

Children with special health care needs - Needs assessment overview

National surveys suggest that at least 13% to 20% of children have one or more chronic health conditions, excluding mental health problems and learning disabilities. Using this prevalence rate, 154,047 Oregon children have special health needs (CSHCN). More children are receiving their health care from managed care organizations (MCO); approximately 80-90% of the 28,688 children enrolled in the Medicaid are in an MCO. The shift from the traditional fee-for-service care places more responsibility on the primary care physician who may not have experience working with children who have complex needs. According to the 1997 joint CDRC/Oregon Office of Medical Assistance Program (OMAP) Satisfaction Survey, parents (Phase I, traditional public assistance families) whose children were enrolled in an MCO reported significantly more difficulty with access, and less satisfaction with care and services. Parents of those children with the most complex needs rated the interpersonal dimensions of the provider-patient relationship lower if they were in an MCO.

Families consistently ask for complete information about their child's condition and assistance navigating through the complicated "systems of care" - how to get what they need. They want services that truly reflect family centered practices, and they are ready to provide input at the policy level as well as at the individual service plan level to ensure that the system address issues of children and families. Eighty-six percent of parents of Phase II children (children receiving SSI or children not living with their birth parents) who were enrolled in an MCO were unaware of the Exceptional Needs Care Coordinator (ENCC) program available as a covered benefit through their MCO. Of those who had used ENCC services, 21% reported that enlisting their help was hard or very hard. Phase I children do not have access to an ENCC. (1997 CDRC/OMAP Parent Satisfaction Survey). In 1999, the CaCoon Nurses provided 6564 care coordination services to 1467 children and families. The Nurses report that they are unable to meet the growing care coordination needs in their counties; the unmet need is at least 30%.

Families are also asking for support services and identify respite care as a top priority. Sixty-four percent of key informant providers reported respite care as a nonexistent resource. More than 120 families requested OSCSHN funded respite care in 1999. Demands were greater than the available funds of $150,000.

In 1995, a survey to dietitians and programs serving CSHCN, identified funding, lack of training for staff and poor community coordination and referral as barriers which prevent CSHCN from receiving nutrition services.

3.1.2.2 Direct Health Care Services and
3.1.2.3 Enabling Services

Table 1 presents a summary of the Oregon assessed needs by Pyramid Service Level.
The Oregon Needs Assessment identified access and availability of services, programs, and insurance as one of three highest priority concerns of the state. Even with the Oregon Health Plan, the Childrens Health Insurance Program, and Medicaid, families and children who need care are not adequately enrolled in a health plan or they live in communities without physicians or dentists who accept Health Plan or uninsured clients. The issues of non-enrollment range from distrust of the system (undocumented, migrants, adolescents) to lack of knowledge and understanding about self care and family care. Access, availability and utilization of specialty health care, mental health and substance use treatment services is lacking for all populations, particularly for parents at risk for abusing and neglecting children and adolescents at risk for negative behaviors. The lack of services is due partially to lack of adequate health plan coverage for the insured and under-insured. Adolescents are particularly concerned about the confidentiality of services, both in school-based or school-related health services and with family health providers. Steps are currently being taken to remedy the gaps in the mental health/substance use treatment system of services through Governor task forces on dual diagnosis and mental health systems.

3.1.2.4 Population-Based Services

Health education and public awareness of prevention strategies was the second of three highest priorities of the Oregon needs assessment. Related to access and availability of services, gaps in public awareness of certain services were identified through interviews with community health leaders. The absence of knowledge by parents and primary care givers was clear throughout the assessment. The assessment revealed that health improvement could arise from public education for simple prevention strategies such as infant gum and tooth care, development of children before age 6, and the direct relationship between parent and adolescent mental health issues to behavioral outcomes.

3.1.2.5 Infrastructure Building Services

Adequate and valid data collection, analysis and interpretation was the third of the three priority concerns of community health leaders. During the needs assessment activities, it became apparent that many crucial data sources were not available. Reliable data support for the qualitative information collected from state and community health leaders and experts was lacking from this needs assessment, particularly in areas of mental health, substance use, and violence indicators. The identified need is therefore to create reliable data sources to create baseline information upon which to build continuous monitoring of the five priority issues. Partnerships with traditional and non-traditional state and local organizations were identified throughout the assessment of issues, especially for those issues which have a strong cross-over into education, justice and social service systems.

Table 1

OREGON TITLE V
SUMMARY OF ASSESSED NEEDS
BY SERVICE LEVEL PYRAMID

2001-2006 Needs Assessment

PRIORITY ISSUES	ASSESSED NEEDS			
	Direct Service	**Enabling Service**	**Population Based Service**	**Infrastructure Service**
Prenatal Care	- Early, comprehensive prenatal care visits	- Universal or presumptive eligibility for all Oregon residents	- Reduced low birthweight incidence, especially among minority population groups	- Assurance of early, comprehensive, and culturally appropriate care
Child Oral Health	- Dentists who accept OHP clients - Dentists who accept CSHCN client	Dental screening prior to first grade	- Dental sealants on permanent molars - Parental education of oral health practices	- Fluoridated community water systems

PRIORITY ISSUES	ASSESSED NEEDS			
	Direct Service	**Enabling Service**	**Population Based Service**	**Infrastructure Service**
Child Abuse and Neglect	- At least 6 home visits/year for high risk families - A/D and mental health treatment services for parents	- Social service programs promoting positive parenting skills	- Positive parenting education for teens	- All types of child care providers appropriately trained and licensed or certified - Cross-agency and public health involvement in child abuse case management - Public health nurse involvement in Community Safety Net - Prevention and public health interventions within judicial and social service systems - Data tools related to child abuse prevention - Data collection to monitor Oregon's Early Childhood System of Services and Supports

PRIORITY ISSUES	ASSESSED NEEDS			
	Direct Service	**Enabling Service**	**Population Based Service**	**Infrastructure Service**
Adolescent Mental Health and Substance Use Prevention	- Mental health and substance use counselors in schools - Primary care providers who screen and refer for mental health/substance use	- Health insurance coverage of adolescents - Mental health and substance use insurance coverage for adolescents - Adolescent contact with health care providers - Early adolescent screening and guidance - High-risk adolescent screening and guidance - Adolescent family members screening and guidance - Referral completion for mental health and substance use treatments - Confidentiality for adolescents seeking care	- School-based and community-based programs - Public health education targeting adolescents and adult family members - Adolescent awareness of information and services	- More data sources to measure adolescent indicators - Data sources to evaluate prevention strategies - Partnership collaboration among state agencies and community groups - Involve families in evaluation of mental health substance use programs/ activities

PRIORITY ISSUES	ASSESSED NEEDS			
	Direct Service	**Enabling Service**	**Population Based Service**	**Infrastructure Service**
Intimate Partner Violence	- Health care providers who recognize, treat, and refer victims of intimate partner violence - Comprehensive health services for victims of intimate partner violence		- Public health education materials for providers and public - Disseminate effective interventions to service and program designers	- Partnership collaboration to identify alternative methods for funding services and programs - Prevention and public health interventions within judicial and social service systems - Train providers, social services, and justice system workers in treatment and referral for victims of intimate partner violence - Primary and secondary data collection to understand intimate partner violence in Oregon - State and local partnerships addressing intimate partner violence issues

Other Needs Assessments

School Based Health Centers: The School-Based Center Program in CCFH performs ongoing needs assessment to evaluate services and outcomes. Below are the results of recent needs assessment activities.

1) SBHC patient satisfaction survey was conducted. Shared with SBHCs via services report, TA or training being considered to address issues identified. It was found that middle school students had more confidentiality concerns than high school students.
2) SBHC "readiness" survey was conducted with all school district superintendents & principals to assess interest in developing a SBHC. Items assessed were perceptions of community support, school board support, availability of space, availability of matching funds. It was estimated that a minimum of 40 communities would be interested and demonstrated "readiness" in developing the model at this time if funds were available.
3) YRBS data was examined to assess risk profiles of students reporting unmet emotional/mental health and AOD needs and their relationship to youth suicide and other risk behaviors. It was found that youth reporting unmet needs in this areas were associated with higher levels of reporting of suicide ideation and attempts.

Family Planning

Vital Statistics and Oregon PRAMS Data. For the first time we are able to estimate state-specific rates of unintendedness. For 1998, the estimated percent of births that are unintended in Oregon is 40% and the the estimated percent of all pregnancies that are unintended is 53%. This is considerably higher than the national Healthy People 2010 goal of 30% unintended pregnancies. The teen pregnancy rate in Oregon continues to go down. The rate for 15-17 year olds is 42.1, which is lower than the national Healthy People 2010 goal of 46.

Annual Local Needs Assessment Data for Family Planning Grant Process. Statewide, the Family Planning Network of over 100 clinic sites served 80,984 clients in CY 1999. This represents 42% of the 192,904 estimated total Women in Need in the State (total

WIN is defined as all teens 13-19 at risk of unintended pregnancy plus women 20-44 at risk and less than 250% of the federal poverty level, and is based on 1995 data from the Alan Guttmacher Institute which was then updated with 1999 PSU population data).

When comparing the percent of OHD grant-supported clients that are women of color to the percent in the statewide population, the numbers for Hispanics show we are doing well: 22% vs. 6%. For African Americans, our client numbers are 3% vs. 2% in the population. For both Asians (2% vs. 4%) and Native Americans (1% vs. 2%), our client profile is lower than for the state.

Research Phase of the Social Marketing Initiative of the Family Planning Expansion Project. Needs assessment research conducted by our contractors included customer satisfaction surveys, clinic observation and staff interviews, interviews with other health and social service providers, focus groups and interviews with potential customers, and a phone survey of women with a recent Medicaid birth. Results included:

- About one third of women who were eligible for Medicaid because of a pregnancy and had not wanted to be pregnant, said they did not think they could get pregnant.
- After a Medicaid birth, women are more likely to access family planning services and to use more effective forms of birth control. We did not study the question of whether women with a previous "pregnancy scare" or abortion might follow the same pattern.
- Young women seem to be ambivalent about sex and/or preventing pregnancy and using birth control. Their ambivalence about using effective birth control is exacerbated by barriers to service and supply access.
- Access barriers identified by current Family Planning clients were limited clinic hours, difficulty scheduling appointments, poor telephone accessibiliy, small number of staff, and lengthy waiting time in the reception area.
- Current clients reported satisfaction with the level of information/counseling they received, but observation indicated they did not receive very much. Potential

customers (in some cases former clients) expressed a need for more information and counseling about options and side effects so that they could find and stay on the best method for them.

- Cost and side effects of methods are two major barriers.
- There is a low awareness about Emergency Contraception, and many women are interested in learning more and having access to it.

3.2 Health Status Indicators

Section 5.4 - 5.7.

Core Health Status Indicator Forms 1, 2, and 3. No additional materials.

Developmental Health Status Indicators Forms 1, 2, and 3. No additional materials. Death rates and other demographic data was not available at the time of the Block Grant submission. The Title V agency will continue to work towards gathering this data for 2001.

3.2.1 Priority Needs

The Needs Assessment identified five priority issues and three major needs that crosses all five issues: *access, education and data*. From this assessment, the following priority objectives were selected for developing State Negotiated Performance Measures and represent key indicators for which data is currently available and which will help Oregon measure accomplishment to meeting the needs. See Section 3.1.2, Needs Assessment Content for discussion on assessed priorities and needs.

1. Increase the percent of pregnancies among women 15 to 44 that are intended
2. Increase the prevalence of folic acid use among women prior to their becoming pregnant
3. Reduce the number of women who use tobacco during pregnancy
4. Increase the observed number of children aged 0-4 riding in cars restrained in child safety seats.
5. Increase the proportion of 8th graders free from tobacco use during the previous month

6. Increase the number of Oregonians who live in a community with fluoridated water systems.
7. Increase the number of students with access to services at a certifed school-based health center
8. Increase access to appropriate care coordination services for CSHCN in Oregon.
9. Develop a statewide data system to support early childhood program needs through multi-agency collaborative efforts.
10. Increase the percent of identified programs/providers who have signed a collaborative working agreement with the Oregon children with special health care needs program.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Forms 2, 3, 4, and 5

FY 2001 Application:

The budget for FY 2001 is based on the Legislative Approved for the 1999-2001 biennium. The budgeted amounts are calculated to be half of the legislative approved spending limitation, which may not be a true reflection of the actual grant awards. The Partnership in FY 2000 includes all Title V Block Grant Funds, all state General Funds not used as match for other federal programs, and all Other Funds, which are those funds that are not Federal or state General, and are typically from private foundations. The programs included in the Federal/State Partnership for FY 2001 include:

Pregnant Women:	Perinatal Program (Block Grant and General Funds)
Children <1 year:	Babies First! (General Funds) Newborn Screening (Other Funds - Fees), WIC - food rebates (Other funds)
Children 1-22 years:	Child and Adolescent Health, Injury Prevention, Dental Health and Oral Health, Teen Pregnancy Prevention, Suicide Prevention (mix of Block Grant and General Funds); School Based Health Centers (General Funds and Other Funds - RWJ Making the Grade Program); CHIP Outreach (RWJ Covering Kids Initiative); Family

Planning (Block Grant and the Family Planning Expansion Project - Other funds) for 35% of total clients, representing all those less than 21 years.

CSHCN: CaCoon, Community Connections, OSCHCN Financial Assistance Program, (Title V Block Grant, mandated state match)

Funds are either retained at the Oregon Health Division, Center for Child and Family Health or distributed to the county health departments for implementing programs at the local level. For all population groups, except CSHCN, both the 1999 Report and the 2001 Application, the allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. The chart below displays the distribution of the Federal-State Partnership to the pyramid service levels.

Distribution of Funds for Form 5

CCFH Program	Distribution of Federal-State Partnership by MCH Pyramid Service Level			
	Direct	**Enabling**	**Population-Based**	**Infra-structure**
Administration				100%
Perinatal - State Level			25%	75%
Perinatal - Local Grants	50%	25%		25%
PRAMS				100%
Covering Kids			25%	75%
Babies First! - State Level			25%	75%
Babies First! - Local Grants	25%	50%		25%
Child and Adolescent - State Level			25%	75%
Child and Adolescent - Local Grants	20%	50%	10%	20%
Injury Prevention			50%	50%
Dental Health			25%	75%

CCFH Program	Distribution of Federal-State Partnership by MCH Pyramid Service Level			
	Direct	Enabling	Population-Based	Infra-structure
Dental Director (2001 Plan)				100%
Teen Pregnancy Prevention - State Level			75%	25%
Teen Pregnancy Prev. - Local Grants (1999 only)	10%	25%		
School Based Health Centers - State Level			50%	50%
School Based Health Ctr - Local Grants	30%	50%	10%	10%
Suicide Prevention (1999 only)			10%	90%
Family Planning - State Level			50%	50%
Family Planning - Local Grants	40%	30%	20%	10%
Womens Health			25%	75%
WIC - Farmers Market			75%	25%
WIC - Food Rebates (to locals)	10%	90%		
Immunization - State Level			60%	40%
Immunization - Local Grants	20%	10%	60%	10%
CDRC	40%	15%	5%	40%

*Title V Federal-State Partnership is the total of Block Grant + Other Funds + General Funds + Local Revenues

The Oregon Health Division meets its 30-30 minimum requirement by transferring 30% of the Oregon Block Grant appropriation to the CDRC for serving the children with special health care needs for FY 2001; no administrative or indirect is retained prior to transfer. The Health Division budget for FY 2001 includes 41.53% or $2,650,919 to be spent on

preventive and primary care for children. The Administrative Costs are defined as indirect charges. The Health Division policy defines indirect costs as: "Costs incurred by an organization that are not readily identifiable but are nevertheless necessary to the operation of the organization and the performance of its programs. These costs include, but are not limited to, costs of operating and maintaining facilities for administrative salaries, equipment, depreciation, etc." The Health Division's indirect charges are incurred at the rate negotiated for Federal Grants. Grantees receiving funds from the Health Division agree to keep indirect costs at or below 10%.

3.3.2 Other Requirements

The required Maintenance of Effort for Oregon is $3,950,427 and the Health Division assures this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The state meets the required three-for-four dollar match. Source of funds is state general funds and county local funds. The state funds are appropriated on a biennial basis by the Oregon Legislature and county funds are appropriated on an annual basis.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3, the Title V Block Grant Performance Measurement System presents the framework for the relationship between the needs assessment and the MCHB Core Performance Measures. Figure 4 is a table of the Core National Performance Measures that must be reported. While Oregon does not yet have reliable data sources for all these measures, strategies are in place for the OHD to build capacity to report on these measures.

Figure 3
TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

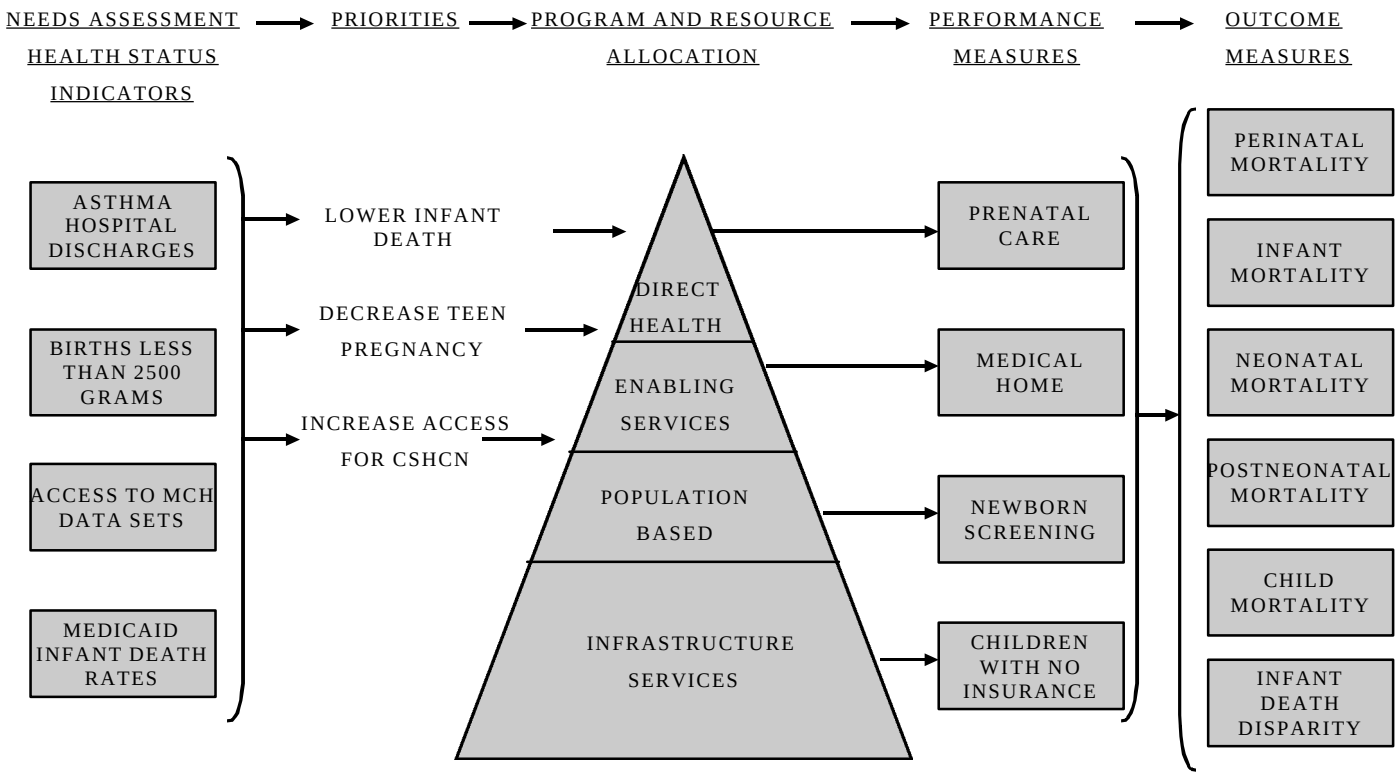


FIGURE 4

PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures 1996-2000	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
S1) Percent of children under 18 who are abused or neglected.			X				X
S2) Percent of physical and/or sexual abuse among women 18-44.		X			X		
S3) Percent of high risk infants in Babies First! meeting developmental standards at the 12 month screening.		X					X
S4) Percent of children 0-4 who are caries free.			X				X
S5) Percent of low-income children 1-4 with iron deficiency.				X			X
S6) Percent of 8th graders free from involvement during the previous month from tobacco.				X			X
S7) Percent of pregnancies among women 15-44 that are unintended.			X		X		
S8) Number of CSHCN receiving appropriate coordination services.	X				X		
S9) Percent of providers in Oregon who participate in an educational experience addressing the health needs of CSHCN.				X		X	
S10) Number of collaborative agreements with state programs/providers in Oregon providing services to CSHCN.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population-Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures 2001-2006	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
S11). Percent of pregnancies among women 15-44 that are unintended			X				X
S12). Percent of women who had live births who took folic acid most days in the month before becoming pregnant			X				X
S13). Percent of pregnant women reporting no tobacco use			X				X
S14). Percent of children 0-4 who are observed riding restrained in child safety seats in cars			X			X	
S15). Percent of 8th graders reporting no tobacco use within past 30 days			X				X

Negotiated Performance Measures 2001-2006	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
S16). Percent of Oregonians living in a community where the water system is optimally fluoridated.				X		X	
S17). Percent of K-12 students with access to a State Certified School-Based Health Center				X	X		
S8). Percent of CSHCN receiving care coordination Services				X		X	
S19). Degree of participation in the collaborative effort of developing a statewide data system to support Oregon's early childhood program needs.				X	X		
S20). Percent of providers serving CSHCN participating in an educational experience.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

Form 11 – No additional materials.

3.4.2 State "Negotiated" Five Year Performance Measures

Figure 4 includes a table of the State Negotiated Measures for the Oregon 2001-2006 Five Year Plan. Form 16 shows a definition of each measure.

3.4.2.1 Development of State Performance Measures

The Title V Needs Assessment established priority needs in Oregon. The State Negotiated Measures represent indicators for which data is valid, currently available in Oregon and which can be reliably tracked over five years. While it would appear that some of the previous measures, such as rate of child abuse and neglect (SP 01) and physical and sexual abuse of women (SP02), are directly related to the Oregon needs assessment issues, these measures were not accurate or the data source was not reliable in measuring performance of current and planned MCH activities or health status of Oregon Title V population. The Oregon Needs Assessment identified data in specific areas as a priority need and effort will be focused over the next five years to continue enhancing and developing data collection and analysis capacity. The measures were selected also

for their relevance to the Oregon Benchmarks and priorities, a statewide quality of life measure system coordinated through the Governor's office.

3.4.2.2 Discussion of State Performance Measures

The ten state measures selected by the Oregon Title V agency reflect current priorities in MCH programs, initiatives and collaborative partnerships statewide. The new state negotiated measures and their supporting activities reflect the focus of MCH programs in CCFH and CDRC to build infrastructure in public health systems for better service delivery and in improving population health through better program delivery. Measures related to pregnancy health and injury prevention are directly related to the reducing mortality rates represented by the six Core Outcome measures. The other measures are related to reducing morbidity or in building data capacity to better analyze indicators and outcomes in the future.

3.4.2.3 Five Year Performance Objectives

Form 11. No additional materials.

3.4.2.4 Review of State Performance Measures

No materials.

3.4.3 Outcome Measures

Form 12, No additional materials. The Oregon Title V Agency has not identified additional outcome measures. As further assessment is conducted for the priority needs, the Agency may identify outcome measures in the future.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

The format for presenting the Annual Plan is the same as for the Annual Report (Section 2.4). Each measure is listed within its pyramid level service category and bullet points summarize the program activities for achieving the goals of each measure.

DIRECT HEALTH CARE

National Goal 1: Percent of SSI beneficiaries receiving services from CSHCN programs

FY 2001 Goal: 8% receiving services
Population: CSHCN

- Continue discussions with the regional social security office to collect data on SSI beneficiaries to match with CDRC's data base. The purpose of these conversations is to be able to more completely and accurately report progress towards national goal #1.
- Revise the information letter CDRC provides all SSI beneficiaries to include specific information about Medicaid eligibility and the application process. In Oregon, SSI beneficiaries are entitled to health coverage through Medicaid but they must complete a separate application in order to receive medical coverage. Information regarding this benefit is not always made available to the beneficiary and therefore, the coverage is not obtained. The CDRC letter will contain information about Medicaid eligibility and instructions on how to apply for benefits.
- Review the letter CDRC provides to SSI applicants who are denied benefits to include information about other health coverages. Even though these families may have been denied SSI due to medical reasons, they might qualify for health insurance through Medicaid including CHIP. Other options include the Family Health Insurance Assistance Program (FHIAP) and the Oregon Medical Insurance Pool (OMIP).
- Explore the feasibility of providing telephone follow-up to SSI applicants to provide assistance and information pertaining to applying for Medicaid benefits.
- Work with State Vocational Rehabilitation Division (VRD) and Disability Determination Services (DDS) to provide continuing education to community providers about SSI for children.

- Work with DDS to provide information to tertiary NICU's about presumptive eligibility for extreme premature infants. For several years the OSCSHN/SSI liaison provided written information and training for hospital staff about eligibility. It appears that referrals from these units have decreased and we need to reinstate this process.
- Continue with CDRC SSI clinical evaluations for eligibility screening.

National Goal 2: Degree (by score) by which the CSHCN Program pays or provides services for uninsured, underinsured or under-served populations

FY 2001 Goal:score 9 out of 9 points
Population: CSHCN

- Continue OSCSHN financial assistance program at the current level of support at three times the poverty level.
- Review the mix of OSCSHN funds allocated to direct and enabling services.
- Review the OSCSHN support for CDRC specialty clinics based on actual reported services to eligible children during FY 2000.
- Continue OSCSHN efforts to manage costs by paying for direct services through CDRC and OHSU clinics, coordinating benefits with other payers and contracting with community providers to provide services at discounted rates.
- Follow-up with families referred to OHP, CHIP and other programs to determine the eligibility status of completed applications and to assist with the process if necessary. Efforts to help families apply and obtain health coverage through other programs will result in additional cost savings to the OSCSHN program.

ENABLING SERVICES

National Goal 3: Percent of CSHCN with medical home

FY 2001 Goal:86% with medical home
Population: CSHCN

- Survey parents whose children receive services at Portland Shriners Hospital for Children and parents whose children receive services in CDRC's Child Development clinics regarding their perception of a medical home. The parent survey will ask parents to identify their child's primary care provider (PCP) and to rate specific characteristics of

care provided in a primary care office. The data will provide us with information on CSHCN with a wide variety of conditions including physical disabilities, developmental and mental health conditions. This data will also help monitor the percentage of CSHCN who have a regular source of primary care. If the family does not identify a PCP, CDRC and Shriners staff will work with the family to assure access to primary care.

- CDRC will survey PCPs identified in the above parent surveys with a similar tool. The goals are to assess if the family's perception of the services they receive from their PCP meet the definition of a medical home, if the PCP's perception of the services provided to the family meet the definition of a medical home, if there are differences in perception between the two groups, and if there are differences between those families who have a medical home and those who do not.
- Survey the PCPs identified through the parent survey about the supports needed in a primary care office to provide a medical home for CSHCN. The survey will be developed collaboratively with the Committee on Children with Disabilities of the Oregon Pediatric Society. It will focus on identifying specific services that would be helpful to each PCP in the care of CSHCN, e.g., assistance with care coordination or provision of written information and computer-based resources on specific conditions and community resources. The ultimate goal is to design technical assistance programs for PCP offices.
- Offer the American Academy of Pediatrics' (AAP) Medical Home training program in Portland. This training program was developed collaboratively by the AAP and Shriners Hospitals. This train-the-trainer model has the potential of delivering this information to PCPs in the twelve CCN clinic sites as well as other PCPs throughout the state.
- Work with OMAP to reconstitute the task force, which is advisory to the Medicaid Medical Director, on quality assurance issues such as identifying/defining CSHCN and improving access to appropriate specialty care.

POPULATION-BASED SERVICES

National Goal 4: Percent of newborns screened for phenylketonuria, hypothyroidism, galactosemia, and hemoglobinopathies.

FY 2001 Goal: 100% newborns screened
Population: Infants

- Complete final updates to the Practitioner Manual and distribute to hospitals, nurse midwives and pediatricians statewide. The manual, last updated in 1995, details the importance of newborn screening and how to submit samples. It also includes information on the disorders. The manual is currently in the process of being revised (May, 2000).
- Maintain and update the Oregon Health Division/Public Health Laboratory web site which contains general newborn screening program information, contact information, the Practitioner Manual and parent brochure.
- Initiate state public health genetics planning process which will include consideration of linking newborn screening data with other pertinent child and family health data for improved health care delivery and outcomes. The planning process will be facilitated by genetics planning grant funds received from MCHB as of June 1, 2000**.**

National Goal 5: Percent of children through age 2 completing age-appropriate immunizations

FY 2001 Goal: 78% of 19 to 35 months olds immunized (4DTP, 3POLIO/ 1MMR/ 3HEPB/ 3HIB)
Population: Children

- Increase the number of resident Oregon two year olds who completed 4 DTP/3 Polio/1 MMR to 80%.
- Increase the number of resident Oregon two year olds who completed 4 DTP/3 Polio/1 MMR/3 Hepatitis B/3 HIB to 67%.
- Increase the number of two year olds enrolled in Babies First and CaCoon who completed 4 DTP/3 Polio/1 MMR to 85%.

- Develop and implement outreach education to providers and parents about immunizing infants and children.
- Renegotiate a consolidated Medicaid Interagency Agreement to support high priority immunization activities.
- Continue support and promotion of WIC and Immunization integration and other child/family health programs.
- Continue provider education on free VFC vaccine for eligible populations and the need for reasonable administration fees and office visit charges. Develop and implement a plan to eliminate use of 317 Vaccine for insured populations.
- Continue support and promotion of public/private partnerships between LHDs and private providers, particularly for ALERT and VFC.
- Use the AFIX (Assessment/Feedback/Incentive/Exchange) model to improve immunization coverage rates in 2 targeted private populations: i) one of the largest health plans in the Portland metropolitan area and ii) one of the priority counties in Southern Oregon who is found to have lower rates than the state average.

National Goal 6: Rate of births per 1,000 among teens

FY 2001 Goal: 26 births per 1,000 among women aged 15-17 years
Population: Children

- Provide leadership and participate in all phases of implementing the Governor's Adolescent Pregnancy Prevention Action Agenda 2000.
- Participate in and monitor the work groups established for the purpose of developing action items for use at the local level for each of the six state strategies. OHD/CCFH Adolescent Health Section staff and the TPP Coordinator will take the lead responsibilities for two strategies; Contraceptive Access and Male Involvement. In addition, OHD will participate in the Indicator Subcommittee who will coordinate refining and reporting of outcomes data and indicators establised in the Action Agenda 2000.

- Continue support for and development a pilot "male involvement" program for teen pregnancy prevention which targets male adolescents in conjunction with development of a new Adolescent Male Health focus with the Adolescent Health Section.
- Participate in an Adolescent Health Team across the OHD involving all program staff involved in adolescent health issues (pregnancy prevention, family planning, HIV/STD prevention, immunization, WIC, women's health, etc.) to explore integration of teen pregnancy prevention programs across service delivery modes.
- Maintain a teen pregnancy prevention media campaign targeting adolescents and their parents through providing local communities with a media kit and necessary media resources to support local campaigns.
- In collaboration with Adult and Family Services, continue development of the STARS Program Oregon's abstinence only program for teen pregnancy prevention. Expand the abstinence only program to include other models or curriculum available for local adoption.
- In collaboration with Adult and Family Services maintain process and outcome evaluations for our abstinence-only program.
- Collaborate with agencies to target specific teen pregnancy prevention activities toward people of color or where other reproductive health access, services or disparities exist.
- Work in collaboration with local health departments, community-based organizations, Planned Parenthood, RAPP (Reduce Adolescent Pregnancy Prevention) or Community TPP Coalitions, the Oregon Teen Pregnancy Task Force, United Way, social service agencies, the State Office for Services to Children and Families, the State Office of Adult and Family Services, and other agencies to integrate teen pregnancy prevention services across the state.

- Publish the next edition of the *Rational Enquirer,* a newsletter targeting teen pregnancy prevention activities, and distribute to over 15,000 partners. Distribution is to adolescent pregnancy prevention agencies, lead staff, and teen leaders.
- Participate in a pilot program developing and providing the necessary tools, technical assistance and coordination of community advocacy to advance local policies on availability of reproductive health care services and family planning services in (high school) School-Based Health Centers.
- Continue to provide onsite technical assistance around the Governor's Action Agenda and other teen pregnancy prevention issues.

National Goal 7: Percent of children receiving dental sealants to prevent tooth decay
FY 2001 Goal: 30% of third-grade children receiving dental sealants
Population: Children

- The OHD, in collaboration with HRSA, has placed full-time dental director in Oregon to enhance the Dental Health Program. The Director will conduct an oral health needs assessment and develop a strategic plan for improving oral health in children.
- The Dental Health Program will seek funding to sustain and expand existing sealant programs.
- The Dental Health Coordinator will continue working with LHDs to help them develop local coalitions and develop and/or sustain existing programs.

National Goal 8: Rate of deaths to children under 14 per 100,000 children caused by motor vehicle crashes
FY 2001 Goal: 3.9 deaths per 100,000 children under 14
Population: Children

- The Injury Prevention Program (IPP) will continue to seek funding options to invest in the collaborative effort to provide inspection clinics for safety seat use.
- The IPP will identify funds to promote the continuation and expansion of the safety seat voucher program.

- The IPP will collaborate with ODOT to build motor vehicle safety capacity in rural counties through development of coalitions and identification of funding opportunities.
- The IPP will work with local Child Fatality Review Teams to assess current need for child safety seats in counties and to provide funding for these seats through the voucher program.
- The OHD will collaborate with ODOT to determine barriers to booster seat use and utilize a media campaign to increase use of booster seats for children ages 4 to 8.
- The OHD will continue to support and facilitate the Area Trauma Advisory Boards for the purpose of coordination of information and activities in injury prevention statewide.
- The IPP will continue to collaborate with Child Safety Seat Resource Center to train additional local health departments as nationally certified child safety seat clinicians.
- The OHD will support legislation for Graduate Driver Licensing and participate in implementation strategies, if passed.

National Goal 9: Percent of mothers who breastfeed upon hospital discharge

FY 2001 Goal:73% of mothers breastfeeding their infants at hospital discharge
Population: Infants

- The OHD Breastfeeding Promotion Committee will continue work on improving breastfeeding initiation and duration rates by addressing and supporting efforts with other groups.
- The OHD will continue to promote the Baby Friendly Hospital initiative with Oregon hospitals. The hospital survey conducted in FY 98/99 will be shared with Oregon hospitals, and a plan developed from this information.
- OHD will present in-depth data analysis around breastfeeding initiation rates and hospital practices. The OHD will continue to promote breastfeeding-friendly work sites and child care sites to Oregon employers and child care providers. An annual list of breastfeeding-friendly employers will be published in August during World Breastfeeding Week.

- The OHD will continue to develop and promote new breastfeeding support pieces for the breastfeeding friendly employer project.
- The OHD will hold a media event during World Breastfeeding Week and will continue to garner media attention.
- The OHD will provide and support continuing education for health professionals in breastfeeding management.

National Goal 10: Percent of newborns screened for hearing impairment

FY 2001 Goal: 20% of newborns screened
Population: Infants

- HB 3246, adopted by the 1999 Legislature, mandated newborn hearing screening in Oregon hospitals and birthing centers with more than 200 births per year, beginning July 1, 2000. This will encompass at least 92% of all Oregon newborns. The bill did not mandate monitoring or tracking of screened newborns.
- The Oregon Health Division reestablished the Newborn Hearing Screening Advisory Committee, which held its first post-legislation meeting in November 1999 and has met monthly thereafter. The advisory committee includes: several audiologists; a physician specializing in ear, nose, and throat conditions; several parents or grandparents of a deaf child; a physician specializing in pediatrics; a physician specializing in neonatology; a representative of a hospital obstetrics department; two deaf adults; a representative of the Department of Education; a representative of the Oregon Health Plan; three representatives of early intervention programs; three representatives of the OHD; a representative of a health insurance company; and other advocates.
- With the held of the Advisory Committee, Health Division drafted and adopted administrative rules, including a definition of a "hearing screening test" as a two-stage process; established a diagnostic protocol, including frequency-specific ABR, and identified audiologic facilities capable of carrying out the protocol; distributed the lists of audiologic facilities to all screening hospitals to be given to parents whose children are

referred for further testing; identified early intervention institutions and distributed lists of EI institutions to diagnostic facilities; wrote and information sheet for parents whose babies are not screened and forwarded this sheet, and a list of screening facilities, to hospitals not providing screening for distribution to parents of all babies born there.

- The Health Division publicized the implementation of the new law by printing a Newborn Handbook which included a page on newborn hearing and is distributed to all new parents, sending out two press releases, giving several radio and television interviews, speaking at local conferences on newborn hearing screening (Eugene, February 2000, and Portland, April 2000), mailing announcements and informational material to primary care providers and creating a website devoted to newborn hearing.
- The Advisory Committee was charged by the 1999 Legislature with preparing a report for the 2001 Legislature regarding recommendations for improving the testing program. In June 2000, the Advisory Committee adopted the following legislative concepts: expand testing to all babies, mandate individual-level reporting for monitoring and program evaluation, and create a tracking and case-finding system It is the plan of the Committee to have these concepts drafted into legislative language and introduced before the end of 2000. The Committee has established a Legislative Strategies Subcommittee to develop a plan for the passage of the legislation.

State Goal 1R: Percent of pregnancies among women 15-44 that are intended

FY 2001 Goal: 50% pregnancies are intended
Population: Women

- Utilizing the first full year of Pregnancy Risk Assessment Monitoring data, Behavior Risk Factor Surveillance System data, and Title X service data, we are able to set a more definitive baselines for measuring improvements between 2000 and 2006. Our goal is still to bring the capacity of the family planning service system to 100,000 low-income Oregonians served annually. Ongoing monitoring and the first evaluation of budgetary investments vs. savings will be prepared during the next year.
- The Family Planning Program will maintain ongoing quality assurance activities to assure program standards are being met through on-site evaluations at local health agencies and by review of grant program annual plans.
- Using results of recently completed client and potential client research, we will work to improve quality of, and accessibility for, services at local clinic levels. Strategies will be developed during calendar 2000.
- The Family Planning Program will continue to incorporate priority requirements of the Title X program, including increasing the involvement of male partners in family planning services, encouraging family participation in the decisions of minors to seek family planning services, and providing counseling to minors on how to resist attempts to coerce them into sexual activities.
- Work to develop training tools for private providers in the provision of comprehensive family planning services will be completed in 2000.

State Goal 2R: Percent of women who took folic acid most days in the month before becoming pregnant

FY 2001 Goal: 35% of women who took folic acid before becoming pregnant
Population: Women and Adolescent Women

- The OHD will partner with the Oregon March of Dimes in three areas for folic acid promotion: professional education, community awareness, and mass media.

- The OHD will train school-based health center nurses about promoting the folic acid message.
- The OHD and March of Dimes will provide and promote the community action kits, "Get The B Attitude", with local health agency programs.
- Mass media promotion will include PSAs in Regal Cinemas throughout the state.
- The OHD will coordinate and strengthen the folic acid message throughout all programs within the Center for Child and Family Health.
- The OHD will promote the folic acid message with OMAP as part of their prevention initiative.
- The OHD will include questions about folic acid on the PRAMS and BRFFS

State Goal 3R: Percent of pregnant women reporting no tobacco use

FY 2001 Goal: 86.5 % pregnant women used no tobacco
Population: Pregnant women

- The Perinatal and Child Health Section at OHD has partnered with OMAP, local health departments, other agencies and providers to include mandatory training, information, and education on tobacco use and exposure in Maternity Case Management services throughout Oregon beginning October 1, 2000.

1) The Perinatal and Child Health Section at OHD plans to continue to partner with the Tobacco Program at OHD in an effort to target public education toward pregnant women and the reduction of passive exposure to pregnant women, infants, and children.

State Goal 4R: Percent of children age 0-4 who are observed riding restrained in child safety seats in cars.

FY 2001 Goal: 70% of children 0-4 observed using car seats
Population: Infants, Children

- The MCH Child Injury Coordinator work plan includes grant application to Department of Transportation for funding to continue the work of certifying local health department staff as safety seat technicians. The funding to defray the cost of health departments

sending clinical staff to be trained is essential in establishing local capacity to provide this service.

- Work plans also include technical assistance in developing and implementing safety seat clinics post certification.
- Work plans also address work to strengthen local transportation safety coalitions, Safe Communities grant sites and Safe Kids coalitions also supports the efforts of the local health department staff. Funding for the voucher program is currently in need of support.
- The MCH Child Injury Coordinator will work with the Alliance for Community Traffic Safety to develop plans to bring an infusion of funds into that program.

State Goal 5R: Percent of adolescent reporting no tobacco use

FY 2001 Goal: 85% of 8th graders reporting no tobacco use within past 30 days
Population: Children

- The 1998 Oregon Public School Drug Use Survey reported 20.4% of 8th graders smoked cigarettes during the last month (80% free of cigarette use). This is a small downward trend between 1996-98. Data for 2000 in not available. Recent past use (30 days) of cigarettes was reported by 15%of 8th graders (85% free of cigarette use within the past 30 days) as measured by the 1999 Youth Risk Behavior Survey. This in an improvement (from 77% free) reported in the 1997 YRBS. However, additional youth may be involved with other forms of tobacco (smokeless, cigars).
- The OHD established a Tobacco Prevention Program in the Center for Disease Prevention and Epidemiology. The CCFH works cooperatively with various elements of the Tobacco Prevention Program. One of the program's strategies include grants to LHDs and schools for comprehensive tobacco prevention activities. A total of 20 tobacco grant projects involving 51 school districts are anticipated to be distributed to schools statewide for 2000-20001. All 36 counties (local health departments or private non-profits) are funded for community tobacco prevention activities. Other core strategies include ongoing county coalition development, comprehensive school-based programs, a

statewide public awareness campaign, the Oregon Quit Line as well as other regional tribal, multicultural outreach and demonstration programs.

- Resources are limited in CCFH to work directly and exclusively on tobacco, alcohol, and other drug prevention programs for the 8th grade population. Staff across the center work cooperatively and collaboratively with CDPE in support of common tobacco education and prevention goals. A few program specific areas (e.g., prenatal/low birthrate, environmental / asthma, school-based health centers) are more specifically related to local or state tobacco prevention efforts.
- School-based health centers (SBHCs; 44 total, of which only eight are in middle schools) provided tobacco, alcohol, and other drug use education, individual screening, or assessments and referral for treatment when students presented with or were identified with these risk factors. Several centers have specifically piloted tobacco cessation programs at SBHCs.

INFRASTRUCTURE BUILDING SERVICES

National Goal 11: Percent of CSHCN with source of insurance for primary and specialty care

FY 2001 Goal: 96% children with insurance source
Population: CSHCN

- Monitor impact of potential changes in the funding of the Oregon Health Plan (OHP), including Children's Health Insurance Program (CHIP). The CHIP program is only funded through December 31, 2000 and funds may not be available to continue the OHP at the current level.
- If funding for either of these programs is limited, the number of referrals to OSCSHN for financial assistance will increase.
- Continue current referral and follow-up policy to OHP, CHIP, Family Health Insurance Assistance Program (FHIAP) and SSI.

- Work with Office of Medical Assistance Program (OMAP) to assure access to CHIP for children with special health needs.
- Partner with OMAP and commercial insurance companies to review the the adequacy of coverage for specialty care. Since the initiation of the OHP, coverage for primary care has increased; however, the payment for specialty services has decreased significantly. This practice has led some health providers to restrict Intake of new OHP referrals. Also, some plans limit coverage for certain services, e.g, durable medical equipment. Both of these have resulted in an increased need for OSCSHN funding.

National Goal 12: Percent of children without health insurance

FY 2001 Goal: 9.4% children without health insurance
Population: Children

- *Goals for Primary Health Insurance Programs:* CCFH was a 1999 recipient of a Robert Woods Johnson Foundation three year grant, the Covering Kids Initiative, designed around three primary goals:
  - – Increase OHP enrollment in under-served, under-represented communities
  - – Identify barriers to enrollment and simplify the OHP application process to reduce barriers and
  - – Increase collaborations to achieve system integration.
- To achieve the first goal, the Covering Kids Initiative (CKI) has set up OHP outreach projects in two rural counties (Union and Jackson) and a non-profit agency in Portland, Outside In, which provides a drop-in medical clinic for street youth. La Clinica Del Valle, a federally qualified health clinic, is the contractor for the Jackson County project. Targeting Hispanic families, La Clinica will expand outreach to Josephine and Klamath Counties during 2000-2001.
- The Union County project, managed by Health Network for Rural Schools (a program of Oregon Health Sciences University) will expand it's scope of rural outreach to

neighboring Wallowa County, and work collaboratively with the Local Health Authority, Center for Human Development, to maximize OHP outreach.

- Outside In will also be able to expand outreach efforts through the placement of a VISTA volunteer at this project.
- In addition to the outreach pilot sites, there are three CKI projects focused on information dissemination to make eligible OHP applicants aware of health insurance coverage options. School Kids, based in Portland, has developed unique collaborations with 15 local schools to design innovative outreach ideas to promote OHP to low-income families through mini-grants of $750 to these schools. The goal for 2001 is to increase the number of participant schools to 20, and/or increase the mini-grants to $1,000.
- The CKI Media Campaign is being developed by the same agency, Children First of Oregon. They are developing a poster, flyers and incentives for the CKI pilot sites to use in their promotional activities. During 2001, the CKI Media Campaign expects to gain access to radio and the news print media as well as coordinate their campaign with a national effort funded by Robert Wood Johnson.
- The Oregon Health Access Project (OHAP), based in Salem, is the final CKI project. OHAP is distributing media campaign materials and OHP applications and building collaborations to advocate for application simplification in a four county area: Marion, Polk, Lincoln and Jackson counties. During 2001, OHAP will also increase the scope of their activities through the placement of a VISTA volunteer.
- CKI has made significant progress in identifying system barriers to accessing the Oregon Health Plan. During 2000-2001, CCFH will explore linking our State Agency Council on Coordination with other state committees working on this issue. The goal is to present specific recommendations to the Governor's Office and OMAP by December 2001.

- The Covering Kids Initiative is primarily focused on 100% utilization of OHP, CHIP and FHIAP insurance plans. The goal for 2001 is to increase participation in these plans by 3%.
- The Center for Child and Family Health has taken on another project, the VISTA Health Links Project, that interfaces with CKI. The VISTA Health Links Project's primary goals are to:
  - Increase WIC Program participation in order to reach 100% of the total eligible population within the State of Oregon by the year 2001.
  - Achieve 90% immunization coverage for children two and under served by WIC, Medicaid, and the Immunization Program
  - Increase access to and usage of program services and benefits
  - Provide more efficient and effective service delivery, including community organization and outreach.
  - Improve customer service of WIC, Immunization, and Medicaid clients served by county health departments/local agencies.
- CCFH places VISTA volunteers in target counties throughout Oregon to assist their WIC and Immunization programs to reach the above goals. VISTA volunteers are in an excellent position to provide education, outreach and assistance regarding OHP applications through the Health Links Project. The goal for FY 2001 is to blend the CKI and Health Links Projects through quarterly staff inservice trainings and coordination of efforts.

National Goal 13: Percent of Medicaid-eligible children receiving a service paid for by the Medicaid Program

FY 2001 Goal: 92% of Medicaid eligible children receiving a service
Population: Children

- The VISTA Health Links Project will continue to develop outreach efforts and systems to promote immunizations, Oregon Health Plan application, and early prenatal access among WIC clients.
    - SafeNet will continue to provide toll-free information and referral regarding health services/issues to Oregonians throughout the State.
    - The Community-Based Application Assistance Project will continue to provide on-site assistance with completion of the Oregon Health Plan application for pregnant women and their families.
    - As part of the Robert Wood Johnson Foundation Covering Kids grant, staff will continue to work with the Office of Medical Assistance Programs (Medicaid) to enhance outreach efforts, coordination, and simplification of the Medicaid application process, including simplifying application materials, simplifying the procedures for obtaining application forms, and simplifying application completion by identifying nontraditional community-based application sites throughout the state.
    - The Covering Kids/Health Links coordinator will convene a regular meeting of all CCFH staff working on Oregon Health Plan outreach issues to coordinate efforts.
    - The Healthy Child Care Oregon project will educate child care providers about the Oregon Health Plan and provide them with information and applications to distribute to their clients/families.

National Goal 14: Degree to which family participates in CSHCN program

FY 2001 Goal: Score of 10 out of 18
Population: CSHCN

- Support development and implementation of a parent-to-parent network in the state.
- Hire a family liaison/coordinator who will promote, expand and ensure family involvement in policy, planning and evaluation of CDRC/OSCSHN programs.

- Participate in planning and sponsoring a Medical Home Training that will include diverse representation of families and emphasize family/professional partnership. Parents will be involved as participants and as presenters.
- Continue to pursue input and involvement of culturally and geographically diverse families throughout the state in policy, planning, training and evaluation activities.
- Encourage community clinics to include families/consumers in planning and evaluation activities of care coordination and other OSCSHN programs and services.
- Partner with parent organizations and other groups, including Family Voices and state interagency coordinating council, to support family leadership.

National Goal 15: Percent of very low birth weight births

FY 2001 Goal:1% of very low birth weight births
Population: Infants

- The OHD will continue technical assistance and support for local counties to provide outreach and case management/home visiting services targeting women at risk for low birth weight infants through MCM and Healthy Start Initiatives.
- The OHD will continue to distribute the PRAMS survey to collect data as it relates to planned/unplanned pregnancy and access to health care in developing programs and policy related to low birth weight.
- The OHD Perinatal program will continue to encourage community assessments as a tool to local health departments to assist in the determination of perinatal services with assistance on evaluating existing and planning future services.
- Title V funding will be used to support the counties as they shift their focus to reflect the MCH pyramid. In an effort to serve a larger population all county health departments have the option of applying Title V funding to assist in their development of a local FIMR (Fetal and Infant Mortality Review) project and/or Oregon MothersCare (OMC), a first trimester pregnancy access program, in addition to traditional perinatal services. We have expanded our concept of FIMR to include fetal, infant, maternal mortality and morbidity

and maternal and neonatal transfers. The OHD will continue to provide technical support and assistance to these local projects.

- The OHD will continue to provide support and technical assistance to programs that provide pregnancy prevention services to reduce the number of unintended and unplanned pregnancies to women and teens at risk for premature birth (teen pregnancy prevention and family planning).
- In an effort to prevent factors contributing to low birth weight and preterm delivery, Title V programs will continue collaborating with the recently initiated Title X program, the Family Planning Expansion Waiver (FPEP) which facilitates pregnancy planning and other health care services such as STD prevention, treatment, and education as well as preconceptual counseling.

National Goal 16: Rate per 100,000 suicide deaths among adolescents

FY 2001 Goal: 8.5 suicide deaths per 100,000 among age 15-19
Population: Children

- The OHD will develop a Youth Suicide Prevention Advisory Board. This board will provide OHD and community networks with oversight in implementation of the suicide prevention plan.
- The OHD will work in local communities across the state to define networks which will take the lead in local implementation of prevention strategies in the statewide suicide prevention plan.
- The OHD will develop a Sate Team made up of representatives of state agencies whose mission includes youth suicide prevention. This team will develop policy and budget recommendations for the next biennium legislative session.
- The OHD will publish and disseminate the state youth suicide prevention plan.

National Goal 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries

FY 2001 Goal: 85% born at facilities for high-risk deliveries
Population: Infants

- Oregon does not have a state categorization of Level II and III NICUs and other specialty and sub-specialty perinatal services. Various methods are being examined to determine levels of care and staffing, insurance, geographic, and policy factors affecting admissions and transfers.
- OHD will continue to work towards identifying and maintaining a database of designated levels of care of every neonatal intensive care unit in Oregon and to assist facilities, providers, and emergency medical services to formalize protocols and agreements addressing perinatal care and transfers.
- The OHD will continue to work toward the assessment, evaluation, and recommendations of regional and statewide data for the appropriateness of hospital care for high risk mothers and newborns.

National Goal 18: Percent of infants born to women receiving prenatal care in the first trimester

FY 2001 Goal: 83% infants born to women receiving early prenatal care
Population: Pregnant Women

- OHD will expand the Oregon *MothersCare* project, a statewide initiative to improve access to early prenatal care, by assisting local health departments and other potential Oregon *MothersCare* access sites to: formalize partnerships with prenatal care providers and other agencies and providers offering MCH services, utilize the link to SafeNet, MCH Hotline, to local prenatal services; and participate in a social marketing campaign for promoting utilization of the improved system. All county health departments have the option of applying any or all of their Title V funding to participate in the Oregon *MothersCare*.
- OHD will continue to work with VISTA HealthLinks to incorporate prenatal access and integration of services for pregnant women into the program.
- OHD will continue to support the Community-Based Application Assistance project to include all local health departments.

- OHD will continue to collaborate with OMAP to market the availability and increase the accessibility of expanded coverage for pregnant women and for children through CHIP.
- OHD will continue to support and collaborate with community-based efforts to increase access to prenatal care and improve birth outcomes such as: African American Infant Mortality Coalition, Community Health Promoter sub-committee, Healthy Start, WIC, and Maternity Case Management.
- OHD has developed a legislative package which to establish presumptive OHP eligibility for prenatal care, raise the income eligibility level to 200%, and provide universal coverage for prenatal care for women who are uninsured or underinsured. OHD will continue to strengthen the partnership between the Title V agency and the Healthy Start Initiative agencies.

State Goal 6R: Percent of Oregonians living in a community where the water system optimally fluoridated

FY 2001 Goal: 25% community water systems optimally fluoridated
Population: All Title V populations

- OHD will establish and maintain community coalitions that will advocate for optimally fluoridated water in communities serving, at very least, 10K or more people
- OHD will partner will children's health advocates to statutorily mandate fluoridated water statewide
- OHD Dental Director will seek continuation or new funding for the advancement of the water fluoridation message and the logistics involved

State Goal 7R: Percent K-12 students with access to a State Certified School-Based Health Center (SBHC)

FY 2001 Goal:6% of K-12 students will have access to a State Certified SBHC
Population: Children

- The Oregon Health Division, Center for Child & Family Health, Adolescent Health Section provides leadership, technical assistance, policy development, oversight,

assurance, data collection, program evaluation, and reporting functions for the State School-Based Health Center (SBHC) Program.

- There were 41 SBHC open and operating in Oregon during FY 98/99. SBHCs provide a comprehensive set of primary care, preventive health services often combined with emotional/mental health care directly within the school setting. SBHCs served 18,171 clients for a total of 70,221 visits during the 98/99 services year.
- The CCFH SBHC program office implemented a State Standards for Certification process effective July 1, 2000. State Standards were written, certification tools and protocols were developed and staff provided necessary technical assistance to local health departments, school districts and SBHCs to prepare for the certification process. Centers will certify as either CORE or EXPANDED depending on their level of operations, staffing, and services provided as defined withing the Standards.
- The CCFH SBHC program office began an upgrade of the encounter (data collection) system. The new data collection system (Clinical Fusion) provides SBHCs with complete patient & clinical management capacity including billing for reimbursement. The SBHC program office expanded its analysis and reporting of patient encounter and services data to include data from all SBHC operating in Oregon regardless of their primary funding source.
- The SBHC program office is working on financial strategies to help stabilize base funding for SBHCs statewide. State general funds were available to 14 of 41 centers in FY 98/99 and 20 of 44 in FY99/00. Two strategies being pursued are a Medicaid administrative match proposal with the state Office of Medical Assistance Programs (OMAP) as well as inclusion of SBHCs within a safety net component of a waiver proposal being prepared for the state Child Health Insurance Program (CHIP).
- The SBHC program office continues to develop necessary communication products, fact sheets, training and resources or tools to support the SBHC program statewide.

State Goal 8: Percent of CSHCN receiving care coordination services

FY 2001 Goal:25% CSHN receiving care coordination services
Population: CSHCN

- Continue to provide care coordination services through the CaCoon program, Community Connections Network clinics and CDRC tertiary level clinics.
- Fund the Community Outreach and Action for Children who are Hispanic (COACH) model in Marion County through OSCSHN funds. The COACH grant funded project ends September 30, 2000. State and county administrators and staff want to continue this valuable project. OSCSHN dollars, have been allocated to continue the program after the grant ends and to replicate the model in other Oregon counties.
- Work with the Commission on Children and Families (OCCF) to explore the feasibility of partnering to replicate the COACH model in 2 - 3 counties with a high population of Hispanic families.Work with the Medicaid Office (OMAP) to explore funding opportunities for CaCoon care coordination services. Possibilities include expanding the Targeted Case Management waiver to include children older than 3 years and billing for care coordination services through Administrative Case Management.
- Continue to work with state partners to improve the collaboration between and among community-based care coordinators.
- Review funding options, including grant support, to add CaCoon nursing time.
- Participate on the interagency team to develop a data warehouse for state programs providing services to children. The Oregon Health Division has been designated as the lead agency for developing this database. Other agencies involved in this effort are the OCCF, Oregon Department of Education, and OMAP. This collaboration will assist programs coordinate activities and avoid duplication and will also provide more complete and accurate data for measuring national and state performance measures.

State Goal 9R: The degree of participation in the collaborative effort of developing a statewide data system to support Oregon's early childhood program needs

FY 2001 Goal: 80% of organizations attend meetings

Population: CSHCN, Infants, Children

- Convene a workgroup to develop an operational definition of CSHCN. Members of the group will include representatives from Commercial Health Plans, the Oregon Health Plan, CDRC, primary health care providers and families. The group will be co-chaired by OHD and CDRC
- Identify agencies representatives and service providers; convene a workgroup to develop a data warehouse for collecting information on children enrolled in Oregon early childhood programs, including home visiting programs. Members will OHD, CDRC, Oregon Department of Education, and the Commission on Children and Families.
  - Define common data elements required by all partners.
  - Define subsets of the larger population.
  - Expand data collection system to include missing elements.
  - Address confidentiality issues when sharing information across agencies.
- Establish health outcomes for early childhood home visiting programs. Measure outcomes and collect data to evaluate the programs' effectiveness.

State Goal 10R: Percent of providers participating in continuing education addressing CSHCN

FY 2001 Goal:5% providers participating in continuing education addressing CSHCN
Population: CSHCN

- This State Goal originally measured the number of physicians participating in continuing education because data on the total number of physicians in the state (the denominator) is readily available. CDRC recognizes the importance of providing training for a broader group of health and education professionals, other providers working with the special needs population and families. During FY 2001 CDRC plans to develop a mechanism for collecting data on the total number of providers serving CSHCN and eventually report on this larger provider population.
- Plan and implement a joint conference between CDRC and the Oregon Department of Education on Autism.
- Plan and present a conference on adolescents transitioning from pediatric to adult health care. The conference will be a joint effort among CDRC, OHSU faculty, the Oregon Health Division, Shriners Hospital for Children and youth with disabilities.
- Work with AHEC and the OHSU School of Nursing to explore long distance learning technology. Ed-net broadcasting was discontinued, but there remains a growing need to provide current information on CSHCN to community providers throughout the state.
- Continue to provide consultations to clinicians at the CCN clinic sites or via teleconferencing; continue the CCN annual conference, coordinator training and other educational opportunities.
- Continue to provide training opportunities for CaCoon nurses through program orientation to new nurses, on site consultations, 1 - 3 regional conferences, Spring 2001 CaCoon conference, and NCAST training.

- Collaborate with the Oregon Commission on Children and Families to provide educational opportunities to paraprofessional home visitors.
- Cosponsor with OMAP an inservice for Oregon Health Plan community-based care coordinators.

4.2 Other Program Activities

Genetics Planning:

CCFH, in conjunction with the CDRC, has received a 2-year Maternal and Child Health Bureau grant (6/1/00-5/31/02) to implement a statewide genetics planning process. This planning process will include a community assessment around data, services, education and policy needs. The grant will fund genetics program staff, statewide planning meetings, focus groups and consultation visits with other states involved in similar projects. Input from consumers and diverse ethnic/racial/cultural group representatives is a key component of the project. A broad-based genetics (and birth defects) advisory council will be established and include consumers, health care professionals, ethicists and numerous other partners to advise the Health Division/CDRC on genetics issues. The project outcome will be a five-year state public health plan for genetics and a proposal to link children and families affected by genetic conditions with appropriate intervention services through integrated or linked data systems.

Womens Health:

Because many public health issues disproportionately affect women, the Center for Child and Family Health has committed itself to developing a women's health agenda at the Oregon Health Division. While CCFH has programs that work with women (WIC, Family Planning, Perinatal Health), we are expanding to address issues which affect women across their life-cycle. Women's health issues to be worked will be heart disease,

osteoporosis, healthy weight for adolescents, and HIV. CCFH will be working collaboratively with OHD's Center for Disease Prevention and Epidemiology in issues of arthritis, and breast and cervical cancer.

The CCFH created the position of Women's Health Program Development Manager and hired into this position in April of 2000.

The Women's Health Program Development (WHPD) Manager will:

1. Coordinate the Women's Health Network (WHN). The mission of the WHN is to form a coalition open to all who share the goal to achieve health and healing for women in Oregon through advocacy, education, research, and networking. The WHN sponsors four lectures a year. The topics of the lectures are on women's health issues relating to research, services, education, or policy.
2. Manage Intimate Partner Violence (IPV) and sexual assault prevention activities. This issue was one of five issues included in the MCH Needs Assessment.
3. Hire a Public Health Educator to coordinate much of the IPV and sexual assault prevention programs and assist with developing a Women's Health Agenda, and implement CCFH's five-year plan around IPV.
4. Create a women's health agenda which will serve as a guide to how we focus our efforts and resources, help identify opportunities for collaboration and integration, and identify what programs needs funding. The first step will be to create a planning group which will consist of key players in women's public health issues.

Implementation of Olds' Home Visiting Model:

The David Olds model, otherwise known as the Nurse Home Visitation Program, is a model in which public health nurses visit mothers in the home beginning during pregnancy and continue through their child's second birthday. The goals are to improve pregnancy

outcomes, promote children's health and development, and to strengthen families' economic self-sufficiency. This model is now being replicated at blueprint sites nationally. In Oregon two counties have started projects, one is an urban county and the other is a rural county. CCFH and CDRC are exploring development of a statewide project to replicate the Olds models in other counties.

Dental Services:

With the addition of a Public Health Dental Director to the Title V array of programs and services, Oregon's oral health initiative will be greatly enhanced over the next few years. The analysis of issues of the Oregon needs assessment consistently rated oral health as the number one health problem affecting children and families. Below is a list of activities the Public Health Dental Director plans to work on during the next couple of years.

1) Implementation of water fluoridation through the State Planning and Fluoridation System Development Initiative.
2) Through the above initiative, the "Healthy Smiles" model was chosen for coalition-building in the Tri-County area (metropolitan Portland), Central Oregon, Southern Oregon and Hood River for community water fluoridation.
3) Encourage organized dentistry and other partners involved or interested in children's oral health to support local and state initiatives for mandated water fluoridation.
4) Develop and distribute informational pieces on the benefits of water fluoridation
5) Through OMAP and other partners, the Early Childhood Caries Prevention Coalition was formed. This Coalition has developed and conducted educational programs and packages designed to aid caregivers in caries identification in infants and toddlers and to facilitate the treatment of young children in the general dentist's office.

6) Maintained the “King Fluoride” fluoride supplement program in the classroom, especially in areas where no or less-than-optimal water fluoridation exists.
7) Supported locally-organized dental sealant campaigns
8) Explored operational feasibility to establish a dental presence in school-based health programs
9) Participated in activities in Primary Care delivery that would augment existing dental services components.
10) Supported any and all activities to establish a pediatric dentistry graduate program at the local dental school, thereby alleviating the critical shortage of pediatric dentists in the state of Oregon

Hunger and Food Insecurity:

Within Oregon we have high rates of hunger and food insecurity as compared to the rest of the U.S. (#1 and #6 respectively). Prior to the recent National Nutrition Summit held in May 2000, OHD led an effort to develop strategies that address hunger and food insecurity in Oregon. These strategies were used as part of the Oregon platform for the Summit. On the local level we have been involved with educating nutrition professionals through involvement with the Portland Dietetic Association's Community Committee. The Nutrition Consultants have also been served as a member of the Oregon Food Bank's Harvest Share working group and as a board member of a local group called Growing Gardens that builds community, apartment, and home gardens in low-income neighborhoods.

Obesity:

The MCH Nutrition Consultants have been working with Vital Statistics on Youth Risk Behavior Survey (YRBS) and the upcoming CD Summary to add questions and analyze data on the prevalence of obesity, overweight, physical activity, sedentary activity, and nutrition quality of Oregon youth. We are members of the North West Obesity Prevention Project which is working to improve health outcomes and eliminate racial and ethnic health disparities for women in Region X. We have organized and lead a working group to develop strategies to decrease the prevalence of overweight and obesity in Oregon youth. The members of this working group represent public, private and school-based agencies and plan to combine their efforts with other obesity prevention interventions in the State. The MCH Nutrition Consultants have been collaborating with staff from Chronic Disease to complete a CDC grant application that would provide resources to help prevent and control obesity and related chronic diseases by supporting the development and implementation of nutrition and physical activity intervention in Oregon.

Nutrition and Physical Education Action Plan:

Oregon has launched planning around promotion of nutrition and physical activity. In February 2000, CCFH collaborated with OHD's Chronic Disease program in sponsoring "Creating A State of Health Summit" in Spring, 2000. In preparation for this summit, a complete assessment report of Oregon data was compiled. This Summit brought together diverse groups around the state to initiate state-specific strategic planning on nutrition, physical activity, and obesity prevention. General guidelines were developed to be used to further create policy recommendations. Following this summit a team of nine individuals representing different agencies attended the *National Nutrition Summit*, sponsored by the US Dept of Health and Human Services and US Dept of Agriculture. Prior to attending, a position paper that addressed the summit topics was developed by a pre-conference working group which included Summit attendees as well as other OHD staff. This

position paper provided specific background policy recommendations that OHD can promote at both the national and state level. It is actively being used in the Oregon Hunger Relief Task Force. A state-level, multi-agency nutrition consultant partnership group has convened to take specific action in developing a plan of action for promoting nutrition and physical activity. This group is building on all the assessment and work already done in order to create the process for an Oregon state nutrition plan. The kick-off for this planning group will be in Fall 2000. Many activities that are currently ongoing will be able to fall under this umbrella nutrition plan for promotion of nutrition and physical activity.

Medicaid and Children with Special Health Needs

CDRC has worked collaboratively with Medicaid on issues related to CSHCN. Staff plans to strengthen our relationship and contribute to making Medicaid work better for this population. Many issues remain to be discussed to ensure that the health needs of CSHCN are met. These include:

1. expand the existing definition of CSHCN within Medicaid to include all of the Balanced Budget Act categories
2. assist MCOs identify CSHCN
3. develop a reporting mechanism to collect specific data on CSHCN enrolled in OHP Managed Care, Fee for Service, CHIP, and those followed by ENCCs
3. work with plan Medical Directors to develop clinical guidelines for CSHCN
4. review Medicaid specifications for defining medical necessity
5. review funding of Title V home visiting services; explore the feasibility of expanding the age covered to 21 years

Adolescent Health:

Male involvement in teen pregnancy prevention: A job rotation agreement was successfully negotiated with another DHS partner, Adult and Family Services (AFS), to staff an Adolescent Male Health position within the Adolescent Health Section. This position is responsible for the strategy development and workgroup activities for the Male Involvement Work Group as it relates to the state Teen Pregnancy Prevention Action Agenda 2000. In addition, an assessment of adolescent male health issues (where health issues or conditons for young males are over-represented or where other disparaties are documented) is being conducted to examine the potential to "cluster" these issues into education, prevention and intervention activities as a means to more effectively reach young males with necessary information and services. Public Health recommendations will be develped in this area at the conclusion of the study.

Adolescent mental health: Adolescent mental health issues has been a focus of the Adolescent Health Section during the last six months. The MCHB Needs Assessment, analysis of the 1999 YRBS data, and analysis of the 1998-99 SBHC program data related to mental health services all suggest that adolescent mental health needs are great. There is inadequate information and understanding regarding unmet emotional/mental health needs of adolescents, gaps in services, access to mental heath services and effectiveness of referral systems for this population. Two efforts (one unsuccessful, one pending) have been initiated to identify additional state staffing in the area of Adolescent Mental Health in order to expand necessary needs assessment activites and build techical assistance, planning and program development capacity. A policy (budget) package has been prepared to expand mental health capactiy within state certified SBHCs and will be considered for inclusion in the 2001-03 biennium. Lastly, the state SBHC program has collaborated with the youth suicide prevention program in developing training capacity in a "gatekeeper" program designed for local communities to improve community-level identification and referral of depressed and/or suicidal youth.

Transition Planning for Adolescents with Special Health Needs: CDRC, in collaboration with the OHD's Adolescent Health Section, faculty from OHSU, DVR, and ODE, will host a conference on assuring the inclusion of health in the transition planning. Key concepts to be covered include: health care is an issue for adolescents and they may need help transitioning from pediatric to adult health care, adolescents have established a relationship with their pediatric health care providers and it may be difficult for both the family and the provider to "let go," and partnerships of health care providers, VR counselors, school personnel, and families are essential in working toward a common goal of independence.

4.3 Public Input

In 1999-2000, the Title V Agency placed emphasis on community and stakeholder input through the needs assessment process. This included regional meetings to discuss issues, problems, barriers and solutions. The Center and CDRC works closely with the MCH subcommittee of the Conference of Local Health Officials (CLHO). General public comments on the FY 2001 Application will be accepted in writing the week of July 24, 2000.

4.4 Technical Assistance

Technical Assistance requests will focus on building expertise, leadership and knowledge for state and local maternal and child health professionals. Leadership training will help MCH leaders increase skills and knowledge internally and externally with partners and in developing and implementing programs. Assistance in developing distance learning programs would provide assist the CCFH and CDRC in utilizing technology to provide continuing education and technical assistance to MCH professionals across, with specific emphasis on rural areas. CCFH and CDRC have begun making arrangements for both these technical assistance activities.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and*

systems development) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adquecy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1)

What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components.

Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are

essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for

administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or

alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-

Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

Organization Charts

- Oregon Department of Human Services
- Oregon Health Division
- Oregon Health Division - Center for Child and Family Health
- OHSU - Child Development and Rehabilitation Center

Biographies

- C. Jerry Sells, MD, MPH, Director, CDRC
- Donalda Dodson, RN, MPH, Director, Center for Child and Family Health, OHD

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

Notes for ERP Forms 1 through 16
Forms 1-15

5.9 National "Core" Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

APPENDIX

A – CDRC - Center on Self-Determination Projects (not available in electronic format)
B – Child and Family Health Needs Assessment Summary (included)
C – Children With Special Health Care Needs Assessment Summary (included)
D - Acronyms

Child and Family Health Needs Assessment and Recommendations for Public Health

SUMMARY

Prepared by
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Oregon Health Division
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800 N.E. Oregon Street, Suite 825
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503-731-4021
June, 2000

DHS oregon department of human services

OREGON HEALTH DIVISION

Available in an alternate format
upon request, 503-731-4021

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This document is available on the web:
http://www.ohd.hr.state.or.us/ccfh/cfhna.htm

Oregon Department of Human Services
Oregon Health Division
CENTER FOR CHILD AND FAMILY HEALTH

Child and Family Health
Needs Assessment
And
Public Health Recommendations

Oregon Health Division's Center for Child and Family Health conducted a broad needs assessment in 1999-2000 to address key health issues affecting women, children and families. The assessment goals were:

- *Assess the health status of women, children, children with special health care needs, and families in Oregon*
- *Identify assets, best practices, and gaps within current systems of care*
- *Produce a working document to be used for program planning by a variety of providers*
- *Collect information needed to build a surveillance system to monitor the health status of women, children, children with special needs, and families*

The information collected through the assessment, and presented in this Summary, is intended to give a foundation for public health planning and policy making at the state and local levels.

ASSESSMENT PROCESS

The assessment process included:

Interviewing people - collecting qualitative information to focus research and policies based on stakeholder's observations, knowledge, and experiences

Researching issues - reviewing professional literature (studies, surveys, evaluations) to identify effective interventions, standard practices, and strategies

Validating problems - analyzing qualitative and quantitative data to determine disparities associated with the issues

Identifying needs and gaps - analyzing the current system of services and recommending strategies for meeting population needs and service gaps

Identifying Community Concerns

A survey was sent to approximately 1,000 persons associated with health programs and services for women, children and infants, and almost 400 responses were received (Appendix A). Out of thirty health issues, fifteen issues were identified as current concerns by the respondents. From these fifteen issues, the Center selected five leading health issues for assessment and planning:

- *Oral health of children*
- *Prenatal care for all women*
- *Child abuse and neglect*
- *Adolescent mental health status and substance use*
- *Intimate partner and domestic violence*

Researching the Issues

Perceptions and Input:

Five regional meetings were held across Oregon with county health department staff and their local partners in October, 1999. These meetings focused on two primary questions for each of the five issues:
What are the barriers to service and program delivery?
What are the solutions to overcome barriers?

Research and review:

The comments from the regional meetings formed the focus for researching literature and conducting key informant interviews to determine risk factors, protective factors, effective interventions and successful strategies.

ASSESSMENT RESULTS

The assessment results identified common needs, improvement objectives, and action strategies for all five issues. The needs represent public health actions that can improve the status of the five health problems. The recommended objectives represent measures of progress toward health improvement. And the recommended strategies provide ideas for state and local partners to plan action on one or more of the assessed health issues.

Overall Needs

Access – to insurance and to appropriate services

Education – for providers, caregivers, parents and youth

Data – for more thorough knowledge and understanding issue status

Recommended Public Health Improvement Objectives

Increase:

- Health insurance coverage for children, adolescents, and pregnant women
- Health care provider visits for Oregon Health Plan eligible clients
- Dental care for young children and in rural areas
- The number of pediatric dentists statewide
- Community water systems with optimally fluoridated water
- Universal quality and comprehensive prenatal care
- Mental health services access and insurance coverage for youth and adults
- Substance use treatment access and insurance coverage for youth and adults
- Nurse home visiting for high risk families
- Health provider and caregiver knowledge of screening and referral for treatment of abuse and substance use
- Education and skills in positive self-care, behavior and parenting
- Data collection and analysis for continuous monitoring of all issues
- Access to and availability of state and local level data

Recommended Strategies for Public Health

Advocacy - by public health leaders to create policies to increase access and services

Partnerships- between public, private and non-profit agencies to collaboratively implement strategies and meet objectives

Outreach - for families eligible to use services and programs

Training - for health providers and caregivers to screen and refer for specific health risk and protective factors

Education - to help parents, youth and children practice healthy behaviors

Data utilization - to continually assess health status and disparities

ADDITIONAL RESOURCES

The Center for Child and Family Health plans to complete a more comprehensive needs assessment by Fall 2000 with the additional information below. The larger volume will serve as a resource for state and local health planners in program design, implementation and evaluation.

- *Health Status Indicators and Program Measures*

The Center is currently compiling health status indicators for measuring goals and objectives for the five issues. Process and program performance measures will also be made available to monitor the objectives and strategies. Statewide and county level data will be presented when available.

- *Program Inventory*
  The Center is compiling a program inventory of state and local organizations delivering programs and services in each of the five issue areas. A list of model programs and services are also being compiled for the five issues.

- *Community Assessment Tools*
  The results of the needs assessment have been limited to a broad statewide view. Targeted assessment of specific populations and communities needs to occur to determine local-level disparities and needs. The Center is developing local assessment tools and processes to help communities assess their own priorities and strategies to effect positive change.

USING THE ASSESSMENT FOR PLANNING

The Center for Child and Family Health expects to create a statewide five-year plan for maternal and child health from this needs assessment. The Center is also available to assist locals in developing local plans around any of the five assessed issues.

THE ISSUE SUMMARIES

The assessment research produced extensive information and analysis of all five issues. This Summary is meant to highlight the following:

Findings

This section provides a description of the health issue – community needs, risk factors, and public health interventions. The information was collected from three types of sources:

1. Community concerns – collected through informal interviews and community meetings with maternal and child health leaders and professionals
2. Data facts – collected from national and state data sources
3. Research findings – collected from professional literature and studies and "programs that work" in Oregon communities

Recommendations for Public Health to Effect Change

This section highlights objectives to assist public health leaders in developing state and local policies and programs. State and local public health organizations might consider these key objectives when setting priorities.

Suggestions for Public Health Strategies

The ideas presented in this section will assist public health leaders in generating action at the state or local levels to begin working on the public health recommendations. Strategies are separated between state and community levels, but organizations can initiate ideas from either category.

Each of the ***Issue Summaries*** represents a thorough assessment and extensive research of the problems and interventions in Oregon. The ***Issue Summaries*** were prepared by Oregon Health Division workgroups and graduate public health students in 1999-2000.

GOAL: Improve the oral health of children by increasing preventive health care services and prevention education.

The health of children's mouths are often overlooked in infant and young children. Dental caries (cavities) is one of the most prevalent infectious diseases known, yet early prevention and treatment is often overlooked by health care providers and parents. Dental caries cause pain, eating discomfort, learning and speech problems, low self esteem, and other health risks if left untreated. Simple, inexpensive interventions are available at both the individual and community level.

FINDINGS

Description of the health issue – community needs, risk factors, and public health interventions.

1. Community Concerns

Communities need dentists who accept children insured by the Oregon Health Plan

Parents and caregivers need to know more about preventing tooth decay

II. Data Facts

According to the Centers for Diseases Control and Prevention, by age 2, only 25% of children had ever visited a dentist; by ages 5 and 7, the proportions increased to 75% and 89% respectively.

The Healthy People 2010 goal is to reduce dental caries so that the proportion of children who have had one or more cavities is no more than 15% among children aged 2-4, 40% among children 6-8, and 55% among adolescents aged 15.

47 % of children aged 3-5 years old report a history of dental caries; 55 % of children 6-8 have a history of dental caries (1992-93 Oral Needs Assessment.)

Early childhood caries, frequently referred to as baby bottle tooth decay, can be a devastating condition often resulting in hospital visits for treatment with costs of $1,500 to $7,000.

Oregon is 45th in the nation for providing community water fluoridation. The Oregon Health Division Drinking Water Section reports that 24% people in Oregon communities have community water fluoridation systems, and 2% of Oregon communities have naturally occurring fluoride. The Healthy People 2010 goal is 75% of people in communities served with optimally fluoridated water, from a baseline of 62 % in 1992.

43% of students in 243 schools (Head Start to 8th grade) were enrolled in the King Fluoride program in 1997-98.

It is unknown how many Oregon children have received dental sealants. The Healthy People 2010 goal is 70% of children between 8 and 14 who have received protective sealants. (1988-1994, 23% of 8-year-olds and 24% of 14-year-olds received sealants in permanent molar teeth.)

45% of parents do not provide their children 18 and younger with preventive oral health. (HP 2000, 98-99 Review)

3. Research Findings

Fluoridation of community water systems is the most effective prevention strategy

Parents who know more about child oral health preventive care can help prevent caries

Standard dental practices should include preventive exams for infant and young children

All children should receive dental sealants on their first permanent molars

RECOMMENDATIONS FOR PUBLIC HEALTH TO EFFECT CHANGE

Leading objectives for state and local public health organizations to consider when setting priorities for action.

I. Increase Access and Availability of Oral Health Care to All Children in Oregon

- < *Increase dentists who accept Oregon Health Plan patients*
- < *Increase the number of pediatric dentists statewide*
- < *Increase the number of children who have had a dental screening prior to first grade*
- < *Increase the number of children with dental sealants on permanent molars*

- *Increase the number of children receiving topical or supplemental fluoride who are not served by community water systems with fluoridated water*

II. Promote Oral Health Prevention and Education in Oregon

- *Increase the number of Oregonian communities which offer optimally fluoridated water*
- *Increase the number of school-based health centers with an oral health component*
- *Increase parental education of oral health preventive practices*

III. Improve the Capacity for Assessing Oral Health Status in Children

- *Increase the capacity to determine baseline health status indicators for child oral health through surveys and other data collection methods*
- *Develop data monitoring tools to assess the child oral health status over time and in each county*

SUGGESTIONS FOR PUBLIC HEALTH STRATEGIES

Ideas to assist public health leaders in developing action plans at the state and local levels.

State Level

1) Encourage the dental profession to increase client services paid by OHP
2) Advocate for more dentists in rural areas
3) Advocate for training for more pediatric dentists
4) Enroll eligible children in the Oregon Health Plan
5) Sponsor dental sealant education campaigns, and support dental sealant clinics
6) Advocate for fluoridation of community water systems by collaborating with community and state advocates and Legislators
7) Design and administer statewide survey to measure the status of child oral health over time and in geographic areas
8) Create statewide targets for increasing children enrolled in OHP
9) Create statewide targets for OHP children receiving dental exams

Community Level

10) Advocate for expanded use of mobile dental clinics, such as NW Medical Teams
11) Promote prevention of baby bottle tooth decay and good oral health practices, such as in workshops, community education programs, schools, home visits
12) Promote child oral health care among parents, especially new parents
13) Provide or advocate for early health screening of infants and young children for oral health

Goal: Improve maternal and infant health through adequate prenatal care

Healthy births are those which the baby is of normal birthweight and the mother is healthy and free of tobacco and other substance use. Low birth weight is the greatest indicator of infant death or disability, and is caused by insufficient nutrition, care, or other preventive services during pregnancy. Healthy babies become healthier children able to learn and grow, and reduce the medical and social costs of subsequent childhood problems. Universal, early and timely prenatal care for all pregnant women is one of the best public health investments available.

FINDINGS

Description of the health issue – community needs, risk factors, and public health interventions.

1. Community Concerns

Quick entry into prenatal care for all women

Comprehensive services, such as case management, substance use treatment, for pregnant women

Adequate funding for prenatal care for all pregnant women

2. Data Facts

In 1997, eight Oregon counties reported that more than 25% of pregnant women smoked.

81.1% of all women received first trimester prenatal care in 1997; however, at-risk groups are well below that level.

Women without first trimester prenatal care, according to 1998 birth certificate data:

1) 32% of unmarried women
2) 33% of Native American women
3) 34% of Hispanic women
4) 35% of teens under the age of 20
5) 35% of women without private insurance
6) 41% of women with less than a high school diploma

8.3% of women who smoked had infants born with a LBW and 7.3% of women who consumed alcohol had a LBW infant

11.2% of babies born to African American women were low birth weight in 1998.

Oregon's low birth weight rate has fluctuated only slightly from about 5.6 per 100 births in 1975 to 5.2 per 100 births in 1997.

3. Research Findings

First trimester and continued prenatal care can help prevent poor birth outcomes.

Prenatal care can save $3 for every $1 spent through the prevention of low birth weight.

Despite the low proportion of pregnancies resulting in LBW babies, expenditures for the care of LBW infants total more than half of the costs incurred for all newborns. In 1988, the cost of a normal, healthy delivery averaged $1,900, whereas hospital costs for LBW infants averaged $6,200. (U.S. Department of Health and Human Services, 2000)

Large disparities exist between racial, ethnic, age and socioeconomic groups regarding access to prenatal care and healthy babies. Uninsured, low-income, teens, racial and ethnic minorities, and undocumented aliens are less likely to obtain prenatal care and more likely to have low birthweight babies.

Tobacco use is the most preventable cause of low birth weight. Teenagers, women who are white, have less than a high school education, are unmarried, or who are low income are significantly more likely to use tobacco.

Alcohol and other drug use contributes to fetal and infant death, deformities, and disabilities.

Barriers to receiving prenatal care in the first trimester include: unplanned pregnancy, which is common among adolescents, low-socioeconomic status, and unreliable transportation or child care.

RECOMMENDATIONS FOR PUBLIC HEALTH TO EFFECT CHANGE

Leading objectives for state and local public health organizations to consider when setting priorities for action.

I. Improve Prenatal Care Access and Utilization

- < *Increase the number of pregnant women with access to prenatal care in the first trimester of pregnancy*
- < *Increase the number of pregnant women who begin prenatal care in the first trimester of pregnancy*
- < *Increase the number of pregnant women enrolled in health insurance plan in the first trimester of pregnancy*

II. Increase Quality and Comprehensiveness of Prenatal Care

- < *Increase the number of all live-born infants whose mothers receive quality prenatal care*
- < *Reduce the incidence of low birthweight and very low birthweight*

SUGGESTIONS FOR PUBLIC HEALTH STRATEGIES

Ideas to assist public health leaders in developing action plans at the state and local levels.

State Level

1) Establish presumptive eligibility and universal coverage for prenatal care
2) Expand Oregon MothersCare sites
3) Work with OMAP to reduce barriers and to simplify OHP eligibility
4) Expand the number of School Based Health Centers which offer perinatal education
5) Identify geographic and demographic disparities in first trimester and adequate prenatal care
6) Use collaborative partnerships to maximize resources and avoid duplication of efforts
7) Improve public and provider education about the importance of first trimester prenatal care
8) Utilize Pregnancy Risk Assessment Monitoring System (PRAMS) data statewide assessments
9) Improve and expand case management and home visiting services
10) Improve behavior risk assessment, intervention, and referral services
11) Expand public education about dangers of tobacco, alcohol, and other drug use during pregnancy
12) Increase state supported smoking intervention programs for pregnant women

Community Level

1) Collaborate with community partners to identify at risk populations and provide services that maximize resources and avoid duplication of efforts
2) Increase public awareness of the importance of early prenatal care

3) Collaborate with other community services to establish early identification and referrals of pregnant women - implement MothersCare
4) Encourage local providers to carefully screen pregnant women for risk behaviors
5) Conduct community assessments to evaluate existing services and identify gaps - implement Fetal Infant Mortality Review (FIMR)
6) Disseminate culturally appropriate materials to ensure information to targeted groups
7) Work with drug and alcohol treatment programs to find slots for pregnant women who need services
8) Encourage local media to publicize effects of smoking during pregnancy
9) Implement smoking intervention standards and encourage agency/provider collaboration
10) Conduct surveys, focus groups or public forums on smoking and pregnancy

Goal: Prevent child abuse and neglect through public health interventions and strategies.

Child abuse and neglect has known detrimental effects on the physical, psychological, cognitive, and behavioral development of children. Many of these effects exert their influence throughout the life span and have extensive social, economic and personal ramifications. Public health's role is to provide a preventive orientation to the child protection system. Prevention of abuse and neglect in a comprehensive network of supports and services seeks to provide all families and children the assistance necessary to prevent it's occurrence (primary prevention) and to successfully identify and provide early intervention when it is not prevented (secondary prevention).

FINDINGS

Description of the health issue – community needs, risk factors, and public health interventions.

– **Community Concerns**

Lack of access and availability of a consistent health care provider for children

Inadequate access to drug treatment programs for parents with addictions

Lack of adequate and healthy child care and respite care

Limitations of Child Protective Services and Community Safety Net guidelines

Heavy caseloads in nurse home visititation programs such as Babies First! and CaCoon

2. Data Facts

In 1998, State child protective services (CPS) agencies reported to National Child Abuse and Neglect Data System (NCANDS) that: just over 900,000 children were the victims of substantiated or indicated child abuse and neglect in1998. State CPS agencies investigated an estimated 2 million reports alleging the maltreatment of almost 3 million children. In Oregon, in 1999 there were 11,241 child abuse and neglect victims, a 10.8 percent increase from the previous year.

Oregon ranks second highest in the nation in the rate of child maltreatment fatalities.

3. Research Findings

The current child protective system is crisis oriented and is in need of a preventive orientation.

While we do not have the empirical knowledge and methods to prevent all forms of child abuse, research evidence points to prevention models (such as home visiting) that have promising effects.

Child maltreatment generally consists of four types: physical abuse, child neglect, sexual abuse and emotional abuse.

Families at high-risk of child abuse and neglect may have several risk factors present: parental alcohol/substance abuse, teen parenthood, unrealistic expectations of the child, heavy child care responsibility, inadequate experience in parenting, negative attitudes toward parenting, having been abused themselves, having children with disabilities, poverty level income, and/or low educational level.

Mothers and fathers are the most prevalent perpetrators of child abuse/neglect. In Oregon they were the perpetrators in 69% of all child abuse cases reported by SCF in 1999.

Oregon families in need of drug treatment determined the most common barrier to receiving treatment was a lack of money or insurance coverage.

Consistent and reliable access to health care, substance abuse treatment, WIC, a high degree of parent-family connectedness, and access to healthy child care/respite care may help address the risk factors and prevent child maltreatment.

RECOMMENDATIONS FOR PUBLIC HEALTH TO EFFECT CHANGE

Leading objectives for state and local public health organizations to consider when setting priorities for action.

I. Improve Access & Availability of Services That Protect Against Child Abuse & Neglect

- < *Increase the number of home visits that at-risk families receive a year*
- < *Increase access to alcohol, drug and mental health treatment programs for parents with current or past addictions*

- < *Increase the number of healthy, safe respite care opportunities for high-risk families*
- < *Improve system of response to culturally diverse families*

II. Improve Healthy Parenting Knowledge and Skills

- < *Increase the number of DHS programs promoting positive parenting skills especially among teenage parents*

III. Improve Public Health Involvement in Community Efforts to Prevent Child Abuse and Neglect

- < *Increase the number of public health nurses participating in multi-disciplinary, cross-agency case management of actual or potential child abuse cases*
- < *Increase the number of Family Support Teams among the counties*
- < *Provide public health leadership to the Early Childhood System of Support*
- < *Train professionals in law enforcement, judicial system, social services, child care, education, and health care to recognize maltreatment of children and address the problem through primary and secondary prevention*

IV. Improve Capacity to Assess and Monitor Progress to Prevent Child Abuse in Oregon

- < *Develop and implement data tools and reports related to child abuse prevention*
- < *Develop a data collection system to monitor Oregon's Early Childhood System of Supports (SB555)*

SUGGESTIONS FOR PUBLIC HEALTH STRATEGIES

Ideas to assist public health leaders in developing action plans at the state and local levels.

State Level

1) Seek funding for the Prenatal and Early Childhood Nurse Home Visitation Program (David Old's model)
2) Encourage and enable state initiatives to provide insurance coverage to all children
3) Advocate for inclusion of comprehensive mental health and substance use screening and counseling as a "covered" primary care service for all insurance plans (i.e. reimbursement for preventive services)
4) Continue to participate in the Early Childhood System of Services and Supports

5) Assist counties in developing a method by which to identify the population of high-risk infants who would most benefit from public health nurse home visitation services.
6) Seek funding for child care health consultants
7) Develop culturally and linguistically appropriate education materials related to child abuse/neglect prevention and the associated risk factors to use in DHS programs
8) Work with SCF to collect and analyze data on disability status among maltreated children.
9) Develop outcome measures for child abuse prevention efforts

Community Level

1) Outreach to increase child enrollment in health insurance programs
2) Increase home visitation capacity by hiring more nurses and seek greater funding for these positions
1) Collaborate with community groups and families to identify the community-specific nature of needed child abuse education materials.
1) Place public health nurses at local SCF offices to provide medical and health consultation
1) Increase educational classes on parenting skills and childhood development (i.e. implement Parent as Teacher program (PAT) and/or Partners in Parenting Education (PIPE))
1) Provide continued education for mandatory reporters

Goal: Promote adolescent mental wellness and freedom from substance use

As adolescents transition from childhood to adulthood they face a wide variety of health risks, which interact and result in complex experiences. All adolescents encounter social, psychological, and educational demands on a day to day basis as they prepare for their future. Adolescence is a time of tremendous change and opportunity. Experts agree that the most significant threats to the health of today's adolescents are behavioral in nature and related to psychosocial factors rather than natural causes (National Research Council & Institute of Medicine, 1999). Therefore not surprisingly, adolescent mental health and substance use problems provide the context for many adolescent challenges. Mental health and substance use are intrinsically related to other aspects of adolescent health such as motor vehicle accidents, school failure, unsafe sexual activity, poor physical fitness and violence. The challenge for public health is to assess the current status of adolescent health and well-being, determine policy priorities, and assure availability and utilization of effective programs and services, to support the overall goal of maximizing the health and functioning of Oregon's adolescent population.

FINDINGS

Description of the health issue – community needs, risk factors, and public health interventions.

1. Community Concerns

Tobacco, alcohol, and illicit drug use

Mental health issues such as depression, stress, suicidal thoughts

2. Data Facts

From the Oregon Youth Risk Behavior Survey 1999 (9th-12th grade)

16% seriously considered suicide in the prior 12 months
6% attempted suicide in prior 12 months
44% had at least one drink of alcohol in past 30 days
30% had five of more drinks of alcohol in a row in past 30 days
4% report drinking alcohol on school property
26% of sexually active youth drank alcohol or used drugs before their last sexual intercourse
25% report smoking cigarettes in past 30 days
43% of smokers began smoking at age 12 or younger

Other Oregon adolescent health information

Between 2,000- 3,000 Oregon students are treated for injuries resulting from suicide attempts each year (Oregon Health Division, 1995)

Approximately one in four 11th grade students report using one or more illicit substances (excluding alcohol and tobacco) 30 days prior to the 1998 Oregon Student Drug Use Survey (OADAP).

The 1998 Student Drug Use Survey shows that 43 percent of eleventh graders, 26 percent of eight graders, and 8 percent of sixth grade students reported drinking in the past 30 days

The 1995 Oregon Household Survey indicates that more than 1 of every 5 (21.2%) Oregonians aged 18-24 have an alcohol abuse or dependency problem

The Oregon Department of Education's Report on Dropout Rates in Oregon High Schools 1997-1998 indicate school staff cited substance abuse as the factor affecting 820 student's decision to drop out

In 1997, in Oregon, 18 teen drivers between the ages of 15 and 19 died in alcohol related accidents

Mental health diagnoses were made (regardless of provider type) in 18% of all visits to SBHC in 1998-1999

A reported 40 % of homeless teenage males and 33% homeless teenage females in Oregon engage in injection drug use.

3. Research Findings

The most significant threats to the health of today's adolescents are behavioral in nature and related to psychosocial risks rather than natural causes.

Mental health and substance use are intrinsically related to the common cluster of adolescent mortalities and morbidities (motor vehicle injuries and fatalities, suicide, violence, and unintentional pregnancies)

A broad based conceptualization of adolescent health issues suggest more common underlying dynamics than differences. Thus, effective strategies to deal with mental health and substance use issues have the potential to bring about change in other major areas of concern related to adolescent health.

RECOMMENDATIONS FOR PUBLIC HEALTH TO EFFECT CHANGE

Leading objectives for state and local public health organizations to consider when setting priorities for action.

I. Increase Access to Care and Services

- *Increase health insurance coverage of adolescents*
- *Increase mental health and substance use health insurance coverage*
- *Expand mental health and substance use counselors in schools*
- *Increase the number of primary care providers who screen and provide guidance*
- *Expand school based and community-based prevention programs*

II. Increase Utilization of Care and Services

- *Increase adolescent contacts with health care providers*
- *Improve early adolescent screening and guidance*
- *Improve screening and guidance for high-risk adolescent population*
- *Increase screening and guidance for adult family members*
- *Improve referral completion for mental health and substance use treatment*
- *Ensure confidentiality for adolescents seeking care*

III. Improve Public Health Education and Knowledge

- *Increase public health education campaign materials targeting adolescents and adult family members*
- *Improve adolescent awareness of available resources of information and services*

IV. Improve Assessment of Adolescent Health Status

- *Increase data sources for measurement of adolescent mental health and substance use indicators*
- *Increase the data sources for evaluating effective prevention strategies*

V. Increase Partnerships with Public, Private and Non-profit Organizations

- *Improve collaboration strategies among state agencies/divisions and community partners*
- *Increase involvement of families in planning and evaluation activities related to mental health and substance use*

SUGGESTIONS FOR PUBLIC HEALTH STRATEGIES

Ideas to assist public health leaders in developing action plans at the state and local levels.

State Level

1) Work with OMAP to ensure that eligible youth receive insurance coverage through *CHIP* or *the Oregon Health Plan*.
2) Work with Department of Education on policy issues related to mental health and substance use services in schools.
3) Advocate for inclusion of comprehensive mental health and substance use screening and counseling as a "covered" primary care service for all insurance plans (i.e. reimbursement for preventive services).
4) Prioritize new School Based Health Centers funds to hire qualified mental health professionals or increase time available to provide services.
5) Encourage primary care providers to utilize the Guidelines for Adolescent Preventive Services (GAPS) in treating adolescents.
6) Compile health statistics on high risk youth.
7) Train health care providers and community advocates to better serve minority and disenfranchised youth.
8) Disseminate research, conference findings, and other relevant data about the health of adolescents to local commissions.
9) Develop an advisory group of interested parents, teens and consumers to assist in data collection, program planning, implementation, and evaluation.
10) Identify research on programs or prevention/intervention strategies which are effective within the school, family, and community domains in reducing mental health and substance use among adolescents.
11) Develop a standardized adolescent health monitoring system which includes mental health and substance measurements and is compatible with Maternal Child Health Bureau surveillance.

Community Level

1) Outreach to increase adolescent enrollment in health insurance programs.
2) Recruit qualified health personnel, specifically who are able to better serve minority and disenfranchised youth.
3) Support use of global life skill developmental approaches rather than narrow categorical risk based approaches.
4) Screen high risk youth for mental health and substance use problems.
5) Develop and refine a community-based referral mechanism for students identified as high risk.
6) Work with the media to promote positive messages about youth.
7) Provide continued education for primary care providers in the area of adolescent mental health and substance use.
8) Provide health education programs for adolescents and adult family members in mental health and substance use issues.
9) Link School Based Health Centers's with a sponsoring community provider.
10) Form advocacy groups to lobby for legislation which is supportive of adolescent health and well-being.

Goal: Prevent intimate partner violence in Oregon through public health interventions.

Intimate Partner Violence (IPV) or domestic violence is an ongoing pattern of psychologically, emotionally, physically and/or sexually abusive and coercive tactics used to gain and maintain power and control over an intimate partner. The most common effects of IPV include mortality, physical and psychological morbidity, economic loss to families and society. Tax-payers and social services agencies pay the economic costs of IPV in increased usage of the health care, welfare, child welfare and criminal justice systems. The causes and prevalence of intimate partner violence and what constitutes effective prevention and intervention are not well understood. Public health can work on IPV at several levels, such as preventing the violence from occurring by changing societal norms and empowering women, limiting the physical and psychological consequences that results from such violence by enhancing services which identify, treating and advocating for victims, and collaborating with law enforcement and policy makers to support victims and keep them safe. There is also a great need for public health to conduct surveillance so we can better understand who is affected, in what way does IPV impact communities, and what programs are effective in preventing IPV.

FINDINGS

Description of the health issue – community needs, risk factors, and public health interventions.

1. Community Concerns

Inadequate capacity in the health care system to respond to intimate partner violence

Local programs feel unable to provide adequate safety plans and resources to clients who are victims

2. Data Facts

It is estimated that more than 1 of every 8 (13% or 123,000) Oregon women 18 to 64 years of age have been victims of physical abuse by an intimate partner during the past year, according to 1998 Oregon Domestic Violence Needs Assessment

More than 1 of every 6 (15% or 123, 400) Oregon children under 18 years of age are estimated to have witnessed the physical abuse of their mothers or caregivers during the past year.

By the most conservative estimate, each year 1 million women suffer nonfatal violence by an intimate.

Four million American women experience a serious assault by an intimate partner during an average 12-month period.

Nearly 1 in 3 adult women experience at least one physical assault by a partner during adulthood.

28% of all annual violence against women is perpetrated by intimates.

During 1994, 21% of all violent victimizations against women were committed by an intimate, but only 4% of violent victimizations against men were committed by an intimate.

In 1993, approximately 575,000 men were arrested for committing violence against women. approximately 49,000 women were arrested for committing violence against men.

3. Research Findings

There is a need for an ongoing statewide and localized data system which tracks and monitors intimate partner violence.

The consequences of violence in intimate relationships are well-documented and include mortality, physical and psychological morbidity, economic loss to families, loss of women's contributions to work, family. Society, health care, welfare, child welfare and criminal justice costs are compounded generationally as women, children and society experience the effects of violence in their lives.

The causes and prevalence of, as well as effective prevention and interventions, are not well understood for intimate partner violence.

A review of case files in three Adult and Family Services (AFS) districts indicate that over half the families on welfare have domestic violence issues.

Nationally, domestic violence is the most common cause of nonfatal injury to women in the United States. It is estimated the lifetime risk of severe injury as a result of domestic violence is 9 percent for women, with a lifetime risk of up to 22 percent for any type of injury resulting from domestic violence

Profile of Victims of Intimate Partner Violence in Oregon:

1) Female
2) 90% are white
3) 13-24 years of age
4) 63% employed
5) 47% have some college education
6) 43% have annual incomes of at least $35,000
7) 39% are married
8) 66% have children in the household
9) No significant regional differences

RECOMMENDATIONS FOR PUBLIC HEALTH TO EFFECT CHANGE

Leading objectives for state and local public health organizations to consider when setting priorities for action.

I. Improve Access to Appropriate Preventive and Intervention Services

- < *Increase the number of health care providers in public and private sectors who recognize, treat and refer victims of intimate partner violence*
- < *Increase the number of persons insured for comprehensive health services necessary for victims of intimate partner violence*
- < *Increase collaboration with partners to educate policymakers and administrators and identify alternative methods for funding services and programs*
- < *Improve system of services among law enforcement, justice, and health care to increase access for victims of intimate partner violence*

II. Improve Public Awareness and Understanding

- < *Increase public health education campaign materials for public and providers*
- < *Increase the dissemination of studies with evaluated effective interventions for program design and implementation*
- < *Improve the training of health care providers and justice system workers in the appropriate treatment and referral for victims of intimate partner violence*

III. Improve Statewide Assessment Capabilities

- < *Increase the understanding of intimate partner violence through surveys or other ongoing data collection and analysis means*

IV. Increase Integration of Services

- < *Increase the number of state and local partnerships with the Oregon Health Division in the field of intimate partner violence*

SUGGESTIONS FOR PUBLIC HEALTH STRATEGIES

Ideas to assist public health leaders in developing action plans at the state and local levels.

State Level

1) Define and describe the status of intimate partner violence as it currently exists
2) Track trends in violence over time
3) Inform public policy makers about the effects of intimate partner violence in order to raise awareness and leverage increased funds
4) Establish the feasibility of replicating Multnomah County's model for universal screening
5) Pilot the incorporation of domestic violence death reviews into existing Child Fatality Review System
6) Utilize the Oregon Behavioral Risk Factor Survey to collect relevant information
7) Develop a standardized survey tool to assist local health departments in data collection
8) Provide technical assistance to assist those seeking to evaluate the effectiveness of prevention programs and policies
9) Collect and disseminate routine and practical measures for program monitoring and evaluation

Community Level

1) Collaborate with community groups and families to identify the community-specific nature of needed child abuse education materials.
2) Collaborate with ethnic groups and community-based organizations and private providers to address training needs with respect to cultural competency and culture-specific health problems.
3) Increase educational classes on parenting skills and childhood development.
4) Implement Parent as Teacher program (PAT).

Appendix A

ANALYSIS OF SURVEY
OF MATERNAL AND CHILD HEALTH PROBLEMS
May, 1999

A survey was sent to approximately 1,000 persons associated with health programs and services for women, children and infants, and received almost 400 responses. Out of thirty health issues, fifteen issues were identified as current concerns by the respondents. Seven different methods of analysis had the following similar results.

Questions asked for each issue:

How much of a problem is this in your community?

Answer: 0 = not familiar with issue; 1 = low, 2 = moderate, 3 = high

What do you think are the top ten problems that public health efforts should focus on?

Answer: 1 = highest, 10 = lowest

Priority Ranking:

FIRST 5 PRIORITIES

- Drug and alcohol use by youth
- Tobacco Use
- Inadequate child oral health
- Child abuse and neglect
- Unintended teen pregnancy (ages 10-19)

NEXT 10 PRIORITIES

- Child mental health problems
- Violence (IPV)
- Inadequate physical activity
- Inadequate prenatal care
- Inadequate nutrition
- Inadequate health & safety in child care
- Sexually transmitted diseases (STD)
- Inadequate immunizations
- Unintended pregnancy (age 20+)
- Childhood asthma

THE LOWEST 15 PRIORITIES

- Childhood obesity
- Youth suicide
- Eating disorders
- Unintended injuries
- Breast & cervical cancer
- Childhood disabilities
- Low birth weight
- Diabetes in women
- Osteoporosis
- Infant mortality
- Sudden Infant Death Syndrome (SIDS)
- HIV
- Genetic disorders
- Child lead exposure
- Childhood anemia

RESPONDENTS

ORGANIZATION TYPE	Received = 397
County health dept.	100
School health, SBHC	73
DHR agencies, MCH advocacy, advisory, CCF	71
Safety net clinics & minority orgs	52
Early intervention, special education	47
Other, unknown	28
OHD-CCFH	26

POSITION/JOB TYPE			
Pub Health Nurse, Comm Health Nurse	95	Admin support	17
Program coordinator, manager	81	Social worker	14
Director, Administrator	49	Nutritionist	7
School Nurse	47	Child care provider	2
Other, unknown	38		
Health Officer, M.D.	29		
Health care support	18		

APPENDIX B

Bibliography and Resources

Internet-Based Resources for Child and Family Health Issues

Listed are major web sites, which will link to additional information.

American Academy of Pediatrics: http://www.aap.org

American Dental Association: http://www.ada.org

American Public Health Association - Publications: http://www.apha.org/journal

Anne E. Casey Foundation: http://www.aecf.org

Centers for Disease Control and Prevention: http://www.cdc.gov
National Center for Chronic Disease Prevention and Health Promotion: http://www.cdc.gov/nccdphp
Division of Birth Defects, Child Development, and Disability and Health: http://www.cdc.gov/nceh/cddh/default.htm

CityMatCH: http://www.citymatch.org

Dept. of Health and Human Services: http://www.dhhs.gov

Dept. of Human Services: http://www.hr.state.or.us

Family Health Outcomes Project, University of California, San Francisco. http://itssrv1.ucsf.edu/fhop (Publication: Selecting Health Indicators for Public Health Surveillance in a Changing Health Care Environment, September 1997)

Health Resources and Services Administration: http://www.hrsa.dhhs.gov

Healthy People 2010: http://www.health.gov/healthypeople

Knowledge Exchange Network: http://www.mentalhealth.org

Maternal and Child Health Bureau: http://www.mchb.hrsa.gov

National Center for the Education of Maternal and Child Health: http://www.ncemch.org/default.html

National Maternal and Child Health Clearinghouse (publications):
http://www.nmchc.org

Office of Medical Assistance Programs: http://www.omap.hr.state.or.us

Office for Alcohol and Drug Abuse Prevention: http://www.oadap.hr.state.or.us

Oregon Health Division: http://www.ohd.hr.state.or.us

Oregon Dept of Education: http://www.ode.state.or.us
Early Childhood: http://www.ode.state.or.us/stusvc/EarlyChild

Public Health Foundation: http://www.phf.org
Community Health Status Indicators Project: http://www.phf.org/chsi_script.htm

Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health In America. The Johns Hopkins University Child and Adolescent Health Policy Center. December 1995. Order from: National Maternal and Child Health Clearinghouse: http://www.nmchc.org

Robert Wood Johnson Foundation: http://www.rwjf.org

Substance Abuse and Mental Health Services Administration:
http://www.samhsa.gov

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APPENDIX C

CHILDREN WITH SPECIAL HEALTH NEEDS

I. ISSUE OR PROBLEM IDENTIFICATION

1. OVERVIEW

Children with special health care needs have complex and long term health, educational and social needs that may require multiple services extending beyond those required by healthy children. It is now estimated that at least 18% of children have special needs and the prevalence of chronic illness and disability is increasing due to advances in science and technology and the resultinig longevity. These children are being discharged earlier from the hospital and specialty services. As the need for more complex health care moves from the hospital to community settings, the need for informed, experienced providers at the community level becomes more critical.

At the same time in Oregon, more children are receiving their health care from managed care organizations. This shift from the traditional fee-for-service care places more responsibility on the primary care physician who may not have experience working with children who have complex needs. In general, findings from a 1997 Child Development and Rehabilitation Center (CDRC) and Oregon Medical Assistance Program (OMAP) joint survey were positive and affirmed that parents were satisfied with their child's care through a managed care organization and rated their child's primary care provider highly; however, subgroups of the population surveyed found access, satisfaction or quality of care in need of improvement.

Families consistently ask for support services and continue to identify care coordination and respite care as top priorities. They want services of a coordinator who has information about their child's condition and is knowledgeable about the multiple systems that provide care. They want someone who can assist them navigate through a complicated managed care arrangement and coordinate care among and between the medical providers and community-based services. Families who are non-English speakers face additional barriers accessing services and communicating with providers. For these families care coordinators can assist providers to understand a family's cultural practice and health beliefs that may affect the provision of services for a child and can help bridge the communication gap.

Within the multiple systems of care there are multiple definitions of children with special health needs and thus no criteria for identifying these children. In addition there are few agreed upon program outcomes and outcome indicators to measure the effectiveness of services provided. These shortcomings compromise our ability to collect accurate and complete data and report information needed to better plan, implement and evaluate programs and services.

2) LEADING CONCERNS

Access and Availability:

- More highly involved children experience significantly more difficulty accessing services and their families are significantly less satisfied with care and service.
- Oregon's minority population is increasing at a significantly higher rate than the caucasean population. Families who have a child with special health needs face a language barrier, limited transportation, limited resources and illiteracy all too frequently in negotiating the health care system.
- Families and service providers consistently identify lack of respite and special day care as serious needs.
- Families and service providers cite knowledge and availability of care coordination services as high priority.

Supporting Data:

- A subgroup of children enrolled in the OHP were identified as more highly involved. Their parents rated 17 separate indicators of satisfaction and access significantly lower than other parents. Access to information, medical advice after hours, specialists, and mental health services were all reported as significantly more difficult for these highly involved children in fee-for-service than in managed care. For 18 of 21 indicators traditional public assistance families (Phase I) were significantly less satisfied or found access to services significantly more difficult than Phase II families (children receiving SSI benefits and those not living with their birth parents). (1997 Oregon Health Plan Parent Satisfaction Survey)
- The state projected a 76.9% increase in the Hispanic population between 1990 and 1998. (Portland State University, census projections - 1990) In 1995 five counties reported that 20% of births were to Hispanic families compared to 11.7% for the entire state. (Oregon Health Division, Center for Health Statistics) In 1998 CaCoon reported 860 contacts to 214 children. This number represents 20% of the CaCoon Nurses's caseload. (Oregon Health Division Annual Report)
- The Maternal and Child Health Bureau reported an increas in the incidence of low birth weight infants in the Hispanic population over the past five years. LBW is associated with increase in medical and developmental problems.
- The Developmental Disabilities Council as well as other state and community agencies have identified building/strengthening the respite and child care infrastructure and training providers for children with special health needs as top priorities. (A Strategic Plan to Improve Access to Child Care for Oregon Children with Special Health Needs and their Families) Sixty-four percent of key informant providers reported respite care as a non-existent resource. (Oregon Statewide Needs Assessment for Children with Special Health Needs, 1995) OSCSHN funded respite care for 120 families at $150,000 in 1999. Demands were greater than the available funds.
- In 1998, CaCoon Nurses provided 7,506 services to 1274 children and families. The nurses report that they are under serving the care coordination needs in their counties by

at least 30%. (Informal survey of County Health Departments - 1997) Only 25% of parents surveyed reported knowledge of the Exceptional Needs Care Coordinator (ENCC) program available as a covered benefit under the Oregon Health Plan (OHP) Of those who had used ENCC services, 21% reported that enlisting their help was hard or very hard. Phase I children do not have access to an ENCC as a covered benefit. (1997 OHP Parent Satisfaction Survey)

- In 1995, a survey to Dietitians and programs serving CSHN identified funding, lack of training for staff and poor community coordination and referral as barriers which prevent CSHN from receiving nutrition services. (The Nutrition Task Force)

Prevention and Education:

- Parents of more highly involved children enrolled in a managed care organization rated interpersonal aspects of the provider-parent relationship lower than those enrolled in fee for service.

Supporting Data:

- Four indicators of the provider-patient relationship, including access to information and medical advice after hours, were rated lower when a child enrolled in a managed care plan. Parents also reported low levels of prevention advice offered by their health care providers. Families living in rural communities were significantly less likely to have a child's primary provider explain things in a way they understood and less likely to have the primary care provider give advice about ways to keep their child healthy. (1997 OHP Parent Satisfaction Survey)

Evaluation and Assessment:

- Many definitions of children with special health needs are currently in use by state agencies, local providers and policymakers. There is little agreement across systems, i.e. health care, educational, social service, public health and families upon the definition, outcomes and effectiveness of programs/services.
- Studies conducted and programs providing data indicate a range of 6% -18% of children have a special health need. If children with behavioral difficulties and those with mental health problems are included in the definition, the incidence has been reported to be as high as 36%. The percent varies depending on the data source.
- The average child served at CDRC has four or more complicated diagnoses.
- Multiple data sources exist for providing information on progress toward achieving performance measures. Without coordination of data sets, information is incomplete and inaccurate.

Data:

- In 1997, 68,727 children 0 - 21 years of age received special education services; 12% received services for low incidence disability including vision and hearing impairments, orthopedic and health impairments, autism, dual sensory impairments and multiple disabilities. In 1999, 1550 children 0 - 3 years, **x%** of Oregon's children in this age group were enrolled in Early Intervention services. (Oregon Department of Education)

- **xxx, x%**, of Oregon's xxxx live births were associated with congenital anomalies. Congenital anomalies are the leading cause of infant death (21%), the second leading cause of children under four years (13%). (Oregon Vital Stats Report - 1996)
- 5,980 children were receiving SSI payments. (SSA June 1999)
- CDRC, the Title V program for children with special health needs, provided 24,537 services to 5905 children and young adults in FY 1999.
- August 1997, over 10,000 children identified as having special needs were covered by the Oregon Health Plan.

3) EFFECTIVE INTERVENTIONS

Care Coordination

Children with special health needs have complex conditions and utilize multiple services provided by many different systems of care. These systems include state agencies with different goals and outcomes, multiple public and private professionals in community-based and tertiary-based programs, and third-party payers for services. Coordinating care in and across these multiple providers can be time consuming, exhausting and frustrating for families. Care Coordination is a critical service and the key to preventing gaps and duplication in service delivery is linking families to needed services and promoting the "effective and efficient organization and integration of resources." (Maternal and Child Health Bureau's definition of care coordination)

References:

Care Coordination outcomes for children with special health care needs, Access-MCH Outcome Measures Workgroup, July 1, 1998.

Inter disciplinary clinics

Children with special health needs often have multiple complex conditions. They need information form a variety of sources and professionals for accurate and complete diagnosis, treatment, and management. The interdisciplinary process which includes a staffing and bringing together of complex issues is important for planning and coordinating the care for these children. A recent study (1998) conducted by the Joseph P. Kennedy administration confirmed the value of the interdisciplinary evaluation for recognizing and understanding the compounding effects of disorders and for providing additional information needed to determine SSI eligibility.

Reference:

Supplemental Security Income (SSI): Report of a Collaborative Six State Evaluation of Interdisciplinary Eligibility Determination in Children with Disabilities presentation by Robert Cooke, MD, Joseph P Kennedy Jr. Foundation; Frederick B. Palmer, MD, Boling Center for Developmental Disabilities; Rhoda Schulzinger, Consultant, Family Policy

Associates; Alan Shafer, Senior Advisor and Barry Eigen, Executive Program Policy Officer, Office of Disability, Social Security Administration; and a Family Representative .

Community-based Care

Community-based care is effective because it improves access to services. In a state as rural as Oregon, the tertiary center can be a great distance. Travel can be difficult for families with no transportation, children who are very ill, and for parents who must lose a day or more of pay because of missed work. The Surgeon General of the United States, C. Everett Koop, MD in the report Children With Special Health Needs: Campaign '87 stated that "Children deserve to live with their families in their own communities, and to share in the everyday experience most Americans take for granted." He also "called for the building of community-based systems of service for children with special health care needs and their families."

Community-based systems, made up of local interdisciplinary teams, provide a forum for health, education, and social services to be shared between the providers and the family. They allow the parent to give the child's history a single time; providers to share reports and findings, ask questions, and make recommendations; the child to undergo testing in a familiar setting; and for local providers to implement and make an effective health plan. The whole team involved with an individual child and family have a much better chance of avoiding gaps and duplications in services as they make plans for how progress might be better achieved for children with special health needs. Also specialists from the tertiary center provide consultation to the local team. These connections extend training to the providers and promote continuity of care between community based and tertiary health.

Public Health Nurse Home Visits

Home visits to high risk infants and women have been shown to be effective in improving access to, and utilization of health and other services. Only a few studies examined the impact of home visiting for families who have a child with a chronic health condition. Home visiting has been a successful strategy to link families to a primary care provider and provide information about community resources. David Old's studies show public health nursing home visits achieve important benefits, have the potential to make a long term difference with high risk families and children, and are an important component of the health service delivery system.

Support Services

In June 1997, the Oregon Child Care Division identified that children with special health needs are not adequately served within the current child care system. Respite care is identified as the number one priority for families but the lack of information about quality

care, access to trained providers, and the cost of care pose a serious need. Other support services such as family support groups and parent-to-parent support are also lacking. Support services make it possible for parents to work or attend education classes; complete every day activities like shopping; participate in activities with their children; and reduce stress. By improving support services for families the risk for child abuse and neglect is decreased.

References:

Oregon Statewide Needs Assessment for Children with Special Health Care Needs, Final Report. The Oregon Health Policy Institute, March 1995.

A Strategic Plan to Improve Access to Child Care for Oregon Children with Special Needs and their Families. The Oregon Developmental Disabilities Council, Oregon Employment Department Child Care Division, and Child Care for Children with Special Needs Work Group/Map to Inclusive Child Care Team, September 1998.

IV. FIVE-YEAR GOALS, OBJECTIVES, STRATEGIES

A. Goal #1 Improve access and availability of Care Coordination Services to Children with Special Health Needs (CSHN)

1. Objective 1.1 Increase the number of families who have knowledge of and who receive services from ENCCs

   a. Work with OMAP and the health plans to enhance the visibility of ENCCs

   b. Provide continuing education on CSHN for ENCCs

   c. Disseminate PASSPORT, a guide for families to improve understanding of the managed care system

2. Objective 1.2 Increase the number of minority families who receive CaCoon home visiting

   a. Sustain the COACH program in Marion County

   b. Replicate the COACH model hiring Promotoras/ Outreach workers in 3 counties.

   c. Partner with other state agencies to determine how we can integrate public health nursing and para professional home visitors

3. Objective 1.3 Improve coordination of services between tertiary health care providers and community.

   a. Continue to work with hospital NICU staff to help families move easily from NICU to community-based services.

   b. Explore grant opportunities to place a Title V care coordinator at an inpatient tertiary center

B. Goal #2 Improve access and availability of community based multi-discipline services.

1. Objective 2.1 Expand Community Connections Network (CCN) to three communities

2. Objective 2.2 Explore grant opportunities and other funding possibilities to add mental health services to one CCN site

3. Objective 2.3 Increase capacity of CCN clinics by 20%
    a. Enhance public relations to community based primary care physicians and providers
    b. Explore grant opportunities to develop a "marketing" plan

4. Objective 2.4 Continue to expand relationship with managed care as a partner in funding CCN

C. Goal #3 Improve quality assurance in health care for CSHN
1. Objective 3.1 Increase provider knowledge about CSHN
    a. Continue to provide inservice programs through CaCoon and Community Connections Network
    b. Provide consultation/mentor to CCN providers and education sessions to a wider community.
    c. Utilize alternative continuing education methods including long distance learning to reach providers statewide e.g., ed-net
    d. Develop self directed learning models for nurses who provide services to CSHN
    e. Coordinate with WIC program in development and implementation of nutrition care protocols for CSHN

2. Objective 3.2 Increase availability of respite care for CSHN
    a. Review OSCSHN current practice to fund respite care
    b. Collaborate with Oregon Developmental Disabilities Council, ARC of Multnomah and other partners to develop the infrastructure for funding providers and training providers

3. Objective 3.3 Increase parent involvement in CSHN programs
    a. Develop a statewide plan for parent involvement at state, community, and individual family levels
    b. Collaborate with community partners to establish a statewide parent to parent network.

4. Objective 3.4 Expand partnerships with State agencies and community collaborators involved with providing services to CSHN
    a. Continue to collaborate with the ODE to assure inclusion of health services for children enrolled in Early Intervention
    b. Develop 5-year plan for addressing transition issues of adolescents moving from pediatric to adult health care.
    c. Work with OHD and OCCF on Senate Bill 555 implementation

d. Work with OMAP and managed care plans to increase access, improve reimbursement for specialty services and develop standards of care for CSHN
e. Increase cross cultural competence of the staff at CDRC including providers of CaCoon and CCN

D. Goal #4 Improve the capacity and process to collect, analyze, and interpret data on CSHN
1. Objective 4.1 Develop a plan for a systematic approach to data collection
a. Collaborate with state and community partners to adopt a common working definition of children with special health needs
b. Adopt a working definition of medical home

2. Objective 4.2 Provide more accurate and complete data for national and state performance measures
a. Collaborate with OHD to gather data through the SSDI grant process
b. Utilize data gathered as part of the MCHB SLAITS Survey
c. Survey families, PCP, to identify number/percent of families who have a medical home and types of services provided
d. Work with SSA and Vocational Rehabilitation to better identify SSI children known to CDRC

E. Goal #5 Enhance/Strengthen community based programs
1. Objective 5.1 Measure impact of programs
a. Develop "outcome" measures and outcome indicators for CaCoon and CCN programs
b. Complete a cost-effectiveness study of the COACH model for providing services
c. Conduct cost-benefit analysis of nutrition services
d. Implement program changes based on evaluation

APPENDIX D

ACRONYMS

AFS	Adult and Family Services
AHEC	Area Health Education Center
ALERT	Immunization Statewide Registry
AOPHN	Association of Oregon Public Health Nurses
ASADS	Adolescent Suicide Attempt Data System
CaCoon	Care Coordination Program
CARIM	Community Action to Reduce Infant Mortality
CCFH	Center for Child and Family Health (OHD)
CDC	Centers for Disease Control
CDPE	Center for Disease Prevention and Epidemiology (OHD)
CDRC	Child Development and Rehabilitation Center
CISS	Community Integrated Service System
CLHO	Conference of Local Health Officials
CSHCN	Children with Special Health Care Needs
DHS	Department of Human Services (Oregon)
DUE	Data Utilization and Enhancement Project
EI	Early Intervention Programs
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FP	Family Planning
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
LHD	Local Health Department
MCH	Maternal and Child Health (refers to population)
MCHB	Maternal and Child Health Bureau
MCHC	Migrant and Community Health Clinics
ODA	Oregon Dental Association
ODOT	Oregon Department of Transportation
OHD	Oregon Health Division
OHP	Oregon Health Plan
OHPI	Oregon Health Policy Institute
OHSIC	Oregon Health Systems In Collaboration
OHSU	Oregon Health Science University
OMAP	Oregon Medical Assistance Programs
ORS	Oregon Revised Statutes
OSCSHN	Oregon Services for Children with Special Health Needs
PHN	Public Health Nurse
PRAMS	Prenatal Risk Assessment Monitoring System
Region X	U.S. Public Health Service
RFP	Request for Proposals
RWJ	Robert Wood Johnson Foundation
SBHC	School Based Health Center
SCF	Services to Children and Families
SIDS	Sudden Infant Death Syndrome
SSDI	State Systems Development Initiative
SSI	Supplemental Security Income
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TWIST	The WIC Information System Tracker
WCHDS	Women's and Children's Health Data System
WIC	Women, Infants & Children Nutrition Program (OHD)
YRBS	Youth Risk and Behavior Survey